State of New York
Department of Health
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Albany New York 12237

ANTONIA C. NOVELLO, M.D., M.P.H.
Commissioner

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June 30,2000

Nancy-Ann Min DeParle, Administrator
Health Care Financing Administration
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. DeParle:

Enclosed you will find New York's amendment to current Section 1115 Demonstration Project, The Partnership Plan, **so** that we are able to implement our Family Health Plus (FHPlus) program.

Family Health Plus was enacted by Governor Pataki and the New York State legislature late last year as part of our Health Care Reform Act of 2000. Its passage reflects an historic and extraordinary consensus among State leaders in the government, consumer, insurance and provider communities to provide comprehensive health care coverage to our most vulnerable populations.

This submission will strengthen New York's Medicaid program by providing health insurance coverage to individuals who now do not have access to it either because it is not offered to them or because they cannot afford it. Moreover, by providing cost effective health coverage to additional lower-income adults, FHPlus will help meet the insurance needs of the working poor, reduce the "welfare" stigma of Medicaid and integrate existing public-funded health care programs so that continuity of care is enhanced.

Similar to the federal "Family Care" proposal which was announced shortly after New **York's** passage of FHPlus, this program will provide a health care benefit package comparable to that provided to children under New York's extraordinarily successful Child Health Plus program. We have also structured FHPlus to simplify the eligibility process and use innovative community-based outreach approaches to assist individuals in enrolling. By providing a new, affordable health insurance option to adults, FHPlus should also accelerate enrollment of children into Medicaid and Child Health Plus.

Because the legislation calls for a January 1, 2001 implementation date, timely approval of our waiver request becomes essential. My staff has already had conversations with Ms. Cindy Mann and her staff to begin the process, and her office has been most helpful in these early stages.

I look forward to your office's favorable review so that we may all move ahead with our goal of expanding the availability of health insurance coverage to lower-income adults.

Sincerely,

/S/

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner of Health

Enclosure

NEW YORK STATE

REQUEST FOR A

SECTION 1115 WAIVER AMENDMENT

June 30,2000

Governor George E. Pataki

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner, New York State Department of Health

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New York State Request for a

Section 1115 Waiver Amendment

Introduction

New York State is pleased to submit this amendment to its current Section 1115 waiver, building upon its existing Partnership Plan to expand the availability of health insurance to the uninsured, working poor. Under the new program called Family Health Plus (FHPlus), this amendment will strengthen New York State's health care system offering comprehensive health care coverage to more than 600,000 low-income adults who have incomes or assets above the current New York Medicaid levels. These individuals do not have access to health insurance coverage or cannot afford it.

The FHPlus program is the result of an unprecedented consensus among government leaders and key consumer and advocate groups, labor organizations and health care providers. Under Governor Pataki's leadership, the State legislature enacted this program as part of the Health Care Reform Act of 2000 (HCRA 2000). Together with the State-funded "Healthy New York program, which will provide employers more affordable health insurance, HCRA 2000 offers significant new options for health care coverage in New York State.

This amendment to the Partnership Plan requests the additional waivers of several provisions of the Medicaid program *so* that New York State can expand eligibility for certain groups and receive federal financial participation in the costs of the FHPlus program.

Eligibility Under the Family Health Plus Program

The FHPlus program will provide comprehensive health care coverage to adults, with and without children, who have incomes or assets greater than the current Medicaid eligibility standards. Individuals meeting the following criteria will be eligible to enroll in FHPlus:

- Permanent residents of New York State.
- Age 19 through **64.**
- Citizens or Medicaid eligible qualified aliens.
- Not eligible for Medicaid based on income and/or resources.
- Not in receipt of "equivalent" health care coverage or insurance.

Parent(s) living with a child under the age of 21 will be eligible if the gross family income is up to:

- 120% of the Federal Poverty Level (FPL) as of January 1,2001;
- 133% FPL as of October 1, 2001; and,
- 150% FPL as of October 1, 2002.

Individuals without dependent children in their households will qualify with gross incomes up to 100% FPL.

While the majority of Medicaid eligibility standards and rules will apply, several aspects of the program will require waivers to encourage participation and ease enrollment. There are no asset or resource tests for FHPlus, nor any co-payments, premiums or other types of cost sharing. Similar to Child Health Plus (CHPlus), New York's extraordinarily successful health insurance program for children, coverage is available when eligibility is determined and enrollment in a plan has occurred (i.e., there is no retroactive coverage). Enrollees will be guaranteed an initial six months of coverage regardless of changes in circumstances. The existing Medicaid fair hearing and notice process will be used for eligibility determinations under FHPlus.

Applicants with equivalent health insurance, as defined under the Health Insurance .Portability and Accountability Act, will not be eligible for FHPlus. Moreover, to prevent employers from reducing their current commitments to provide health insurance (crowd out,) current insurance availability will be measured during the application process. The State will monitor changes in insurance coverage among applicants. Should crowd out occur, the enabling legislation requires that individuals wait six months (with certain specified exceptions) before they are able to enroll in FHPlus.

Services Provided Under the Family Health Plus Program

A comprehensive benefits package, similar to that provided under the State's CHPlus program, will be provided to individuals enrolled in FHPlus. Services will be provided through managed care organizations and will include:

- Physician services;
- Inpatient and outpatient health care;
- Prescription drugs;
- Smoking cessation products;
- Lab tests and x-rays;
- Vision care;
- Speech and hearing services;
- Durable medical equipment;
- Home health service (short term, acute care in lieu of hospitalization, up to 40 visits per year);
- Family planning services and supplies;
- EPSDT services;
- Emergency room services;

- Emergency ambulance transportation;
- Inpatient mental health and alcohol and substance abuse treatment (30 days per year);
- Outpatient mental health and alcohol and substance abuse services (60 visits per year);
- Diabetic supplies and equipment;
- Radiation therapy, chemotherapy and hemodialysis; and,
- Dental services (to the extent offered by the plan).

Similar to CHPlus and commercial and employer-sponsored health insurance plans, long-term care services, non-prescription medications (except smoking cessation products) and non-emergency transportation are not covered under FHPlus. Moreover, because all services are to be provided through managed care plans, there are no "wrap-around" fee-for-service provisions.

Family Health Plus Service Delivery System

An initial Request for Application will be distributed to the 37 insurers already participating in Medicaid managed care or CHPlus. Plans will be screened for current financial stability, positive survey outcomes and network capacity. By using existing plans with the proven ability to meet quality assurance, access and reporting requirements, the service delivery system will be more reliable and effective.

Despite plan recruitment efforts, it is possible that fewer than two FHPlus plans may be available in a county, particularly in low density or rural areas of the State. While only one FHPlus plan may be the sole option for obtaining care, network requirements provide choices between and among providers. In areas where there is insufficient managed care capacity, State legislation also enables the State to purchase a prepaid benefit package from a commercial insurer.

Rates will be developed utilizing the existing Medicaid managed care rate setting process. Rates will be all inclusive and fully capitated, without carve-outs.

The State will monitor the quality of care provided by FHPlus plans using a system built upon the existing Partnership Plan Quality Monitoring Plan. Key components of the monitoring will include internal quality improvement systems within plans, external monitoring and data collection, on-site reviews, and consumer satisfaction surveys. Grievance and appeals processes will assure that both the plans and the State provide full access for participant's complaints, and protection of their rights.

Application and Enrollment Processes

The FHPlus legislation streamlines the eligibility and enrollment process. A simplified application form will be designed to screen and assess eligibility for Medicaid, CHPlus and FHPlus. The application and annual recertification processes will be integrated with traditional Medicaid eligibility reviews to assure that applicants are directed to the appropriate program. Care will be taken to assure that applicants who are eligible for traditional Medicaid will be enrolled in that program.

Effective transitions will be established between Medicaid, FHPlus and CHPlus, *so* that when changes in income, resources, or age occur, continuity of care is assured. For example, those enrolled in traditional Medicaid, but found ineligible during recertification based on income or resources, will be assessed for FHPlus. Young adults who become ineligible for CHPlus based on age will be assessed for Medicaid and FHPlus.

While local social services districts will continue to be able to accept applications for Medicaid and FHPlus, the program will also use enrollment facilitators to ease the application process. Our initial feedback concerning this approach in the CHPlus program, upon which the FHPlus program will build, has been very positive.

Enrollment facilitators will be sited at community locations and at convenient times for working families and individuals. It will be their responsibility to assist individuals in completing the combined and streamlined application for the various programs. These community based groups will be fully trained to screen applicants for eligibility under all programs, using a joint Medicaid/CHPlus/FHPlus application with standardized definitions and a simplified format.

The facilitators will also provide impartial and helpful information to assist in the selection of a participating plan and a primary care physician. Household members will be encouraged, but not required, to participate in the same plan as other FHPlus, CHPlus or Medicaid managed care family members. Because FHPlus is a voluntary, rather than mandatory program, no auto-assignment will be used.

The annual recertification process will also be eased by the use of a mail-in process, and availability of enrollment facilitators to provide assistance.

Outreach and Publicity

New York State will develop a comprehensive plan for FHPlus outreach that will complement and build upon the efforts currently in place for the CHPlus program. FHPlus will be marketed as a health insurance program for low-income individuals and families and will be targeted to reach potentially eligible populations.

In addition to statewide publicity, education and outreach activities, facilitators and plans will also be an important source of information about the availability of FHPlus. Protections are built into the FHPlus program to ensure that such activities are conducted appropriately.

Family Health Plus Administration

The Department of Health (DOH) will administer the FHPlus program. The DOH is the designated Title **XIX** single state agency, and is responsible for administration of the current Pertnership Plan waiver as well as the CHPlus program. FHPlus administrative functions will be integrated with current Partnership Plan and CHPlus activities such as expansion of the enrollment facilitator activities, rate setting, quality assurance monitoring, patient survey, research and reporting. This approach will reinforce the goal

of assuring continuity of care and effective management and oversight, while avoiding establishing new and duplicative administrative structures.

Purpose and Outcomes

This waiver amendment will allow New York State to continue to address the original Partnership Plan waiver objectives of quality assurance, access, improved health outcomes and cost effective service delivery. Other outcomes of the demonstration will include:

- Supporting the goals of welfare reform by assuring that employed individuals are able to continue working with adequate health insurance.
- Testing the effectiveness of a CHPlus-type service package for adults.
- Promoting health insurance as an item that is obtained for a family as a whole, rather than only individual members of a family.
- Assuring seamless transitions for individuals between and among the CHPlus, Medicaid, FHPlus and Healthy New York health insurance programs.
- Identifying and testing means to streamline obtaining and maintaining eligibility in publicly funded programs, transitioning New York State Medicaid from a perceived "welfare" support to a health insurance program.
- Assuring that individuals and families seeking health coverage are given the opportunity for a "full" Medicaid determination.

Research and Evaluation

The FHPlus demonstration will provide timely information for New York State and the Health Care Financing Administration to:

- Understand the size, nature and utilization patterns of an expansion population which is currently uninsured.
- Provide information on the effectiveness of a facilitated and simplified enrollment process.
- Measure the continuity of care and health outcomes for CHPlus "graduates."
- Determine whether the availability of insurance leads to a greater likelihood of retaining employment.
- Assess the improvements in prudent health service use through managed care.
- Determine the impact on existing employer insurance plans when publicly funded insurance coverage is introduced.

Waivers and Amendments Requested

New York State is requesting waivers **of** certain statutory and regulatory requirements necessary to implement FHPlus as defined in State legislation. While several waivers have already been approved under the original Partnership Plan, additions, modifications and amendments are required based on the nature of this new program. In summary, the major waivers being requested include:

- Eligibility standards and income and resource requirements, **so** that individuals with higher incomes than current Medicaid standards can enroll in the program and that we can modify the "disregard" process to ease the eligibility process.
- Amount, duration and scope of services, **so** that the comprehensive package of services can be provided, although the package is not equal to that provided under the traditional Medicaid program.
- Statewideness and freedom of choice, to reflect that the types and degree of selection of managed care plans may not be comparable statewide and that services will only be provided through a managed care insurance product.

Similarly, the budget neutrality formula, and the detailed terms and conditions under the Partnership Plan will require amendments and revisions. While many of the Terms and Conditions are applicable to FHPlus, others are not, such as those associated with auto-assignment, mandatory placement in managed care, requirements for special needs plans, phased in implementation and others.

CHAPTER ONE: INTRODUCTION AND BACKGROUND

A. Introduction

New York State is proud to submit this amendment to its current Section 1115 (a) waiver, building upon its existing Partnership Plan to address the problem of the uninsured, working poor. Under the new program called Family Health Plus (FHPlus), the amendment will strengthen New York State's health care system, offering comprehensive health insurance to over 600,000 additional low-income adults who have incomes or assets above the current New York Medicaid levels, and no access to health care.

The FHPlus program was established in New York State legislation in late 1999 following an unprecedented consensus of key State leaders in health care, labor organizations, consumer advocate groups and government. Through solid support and advocacy for this new program, the enacting legislation was designed, negotiated and passed in one session. This dramatic process signals both the critical nature of the problem of the uninsured, and the clear consensus among New York State leaders concerning the most efficacious solution.

New York State operates the largest Medicaid program in the nation and, with its diverse population, has historically provided an effective testing site for federal initiatives. The Partnership Plan was a forerunner to many other state health reform demonstrations, and the Child Health Plus (CHPlus) program was one of the first such programs nationally. Through its new FHPlus program, New York State will provide a comprehensive demonstration site for the Health Care Financing Administration (HCFA) to address the problem of the adult, low-income uninsured. FHPlus, like current federal proposals under discussion, will provide comprehensive benefits modeled on commercial or employer benefits using a managed care delivery system. The legislation includes several features designed to reduce the "welfare stigma" including community based enrollment, some relaxation of requirements perceived as onerous by applicants, and less complex standards and operations. By using managed care services and selected benefit limits, the program will prove cost effective.

To assure that FHPlus does not become another separate, complex program in the myriad of public health supports, every effort is being made to integrate its operations, enrollment, service delivery system and administration with the State's traditional Medicaid and CHPlus programs. By using the Partnership Plan waiver amendment process, this integration is more fully assured.

This amendment to the Partnership Plan requests the additional waivers of several provisions of the Medicaid program so that New York State can expand eligibility for certain groups and receive federal financial participation in the costs of the FHPlus program.

B. New York State's Efforts to Expand and Improve Health Care Coverage

Recognizing the problem of the uninsured, New York has already increased the percentage of low-income families with health coverage through a variety of initiatives:

1. Medicaid Eligibility

Since the inception of New York State's Medicaid program, the State has recognized the importance of health care coverage and therefore has extended its program to persons with incomes above cash assistance levels: the "medically needy" population. Moreover, New York State provides medical assistance not only to families but also to its "Safety Net" population -- single individuals and childless adults age 21-65 who are not certified blind or disabled. The New York State Medicaid program's income limit for low-income pregnant women and infants was raised from the medically needy income level to the current level of 185% of the net Federal Poverty Level (FPL). Beginning November 1, 2000, New York State statute will again increase this income level, to 200% FPL.

The income limit for children was raised from the medically needy income level to the current levels of 133% FPL for children between one and six, and 100% FPL for children aged 6 -19. A State Plan Amendment is pending HCFA approval which would have the effect of raising eligibility to 133% FPL for children age ***6*** -19.

As a result of welfare reform, New York State now provides for earned income disregards **(47%** adjusted annually) which apply to those families who have earned income and whose net countable income is below the Low Income Families (LIF) standard. New York has also implemented a more generous disregard of resources for this group.

In addition, since January 1, 1999, most children eligible for Medicaid who are under age 19 are guaranteed Medicaid coverage for 12 months. Each time eligibility is determined, children under age 19 who are found fully eligible for Medicaid will be entitled to 12 months of continuous coverage regardless of changes in income or circumstances.

2. Child Health Plus

Beginning in 1990, New York State established its CHPlus program. Significantly expanded in 1996, New York State's comprehensive health insurance plan for children became a model for the national State Child Health Insurance Program (SCHIP). CHPlus has improved child health by increasing access to primary and preventive health care through a subsidized insurance program. Currently, New York's low-income uninsured children under age 19 whose families have a gross income of less than 250% of the gross FPL are eligible for a comprehensive health benefit package that emphasizes preventive health care. As of April 30, 2000 approximately 500,000 children were enrolled in this program.

3. Partnership Plan

New York State, under its original Partnership Plan Section 1115 Waiver, is implementing a mandatory Medicaid managed care program. This program is designed to improve the health of recipients by providing comprehensive, coordinated and accessible care. Approved for the period July 15, 1997 through March 31, 2003, this demonstration currently includes: phased-in mandatory enrollment of 2.2 million Medicaid recipients into managed care plans; the provision of federal financial participation for New York State's Safety Net population; development of special needs plans (SNPs); benefits counseling; and a five-year $1.25 billion program to assist eligible hospitals in transitioning to managed care.

Under the Partnership Plan, New York has maintained high standards for managed care plans serving the Medicaid population while assuring cost effectiveness of the health care system.

The Partnership Plan is operational in 13 upstate counties and in certain zip codes in New York City. This first phase in New York City includes parts of Manhattan and Brooklyn and all of Staten Island. As of April 30, 2000 total Medicaid managed care enrollment (mandatory and voluntary) was 670,000. Thirty-four full risk managed care plans participate in the Medicaid managed care program.

4. Local Initiatives

Some local districts have implemented a variety of health care initiatives to provide health coverage to their uninsured residents. For example, Westchester County Department of Social Services has recently taken steps to improve the Medicaid and CHPlus application process for health coverage, particularly for families with children, through the use of aggressive and creative outreach and marketing techniques. Together with the County Department of Health, the local district plans to develop a media campaign, initiate steps to outstation workers at the local Department of Health, and to develop a request for proposals to acquire systems' support software.

In addition, the Robert Wood Johnson Foundation funded three pilots, called 'Covering Kids," in New York City (at Bronx Lebanon Hospital), in the Finger Lakes region (Allegany, Steuben, Schuyler and Yates counties), and in the tri-county Capital District area (Albany, Rensselaer, and Schenectady), to do outreach and enrollment. These pilots field-tested the facilitated enrollment process by using the revised Growing Up Healthy application, which included CHPlus as well as Medicaid and Special and Supplemental Food Program for Women, Infants and Children (WIC). It was their experience, in part, which led to the current version of the Growing Up Healthy application.

C. Current Medicaid Standards, Enrollment and Trends

As a result of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), New York delinked Medicaid and Public Assistance and created comparable Medicaid eligibility categories to parallel the new public assistance eligibility groups. The new Medicaid eligibility categories for LIF (consistent with federal requirements), and for the Safety Net Population, use the financial standards of the public assistance programs. Individuals who are not eligible under LIF Medicaid may be eligible for Medicaid under New York State's medically needy Aid to Families with Dependent Children (AFDC) related eligibility group.

As required under PRWORA, families that lose Medicaid eligibility under LIF due to increased earnings and who were LIF eligible for at least three of the previous six months are eligible for Transitional Medical Assistance (TMA). TMA is provided for an initial six month period; if the family continues to have a dependent child in the household, and has earned income under 185% FPL and returns the required mail in recertification, the family is eligible for an additional six months of TMA. A Medicaid extension of four months is also provided to families that lose LIF eligibility due to the collection of or increase in child/spousal support; no income limitation applies to the four-month child support extension.

The number of individuals enrolled in New York State's Medicaid program, including those who are receiving cash assistance and Supplemental Security Income (SSI) and those who are medically needy, began declining in March 1995 from its high of 3.2 million persons. Beginning in November 1998, however, Medicaid enrollment has been fairly steady at approximately 2.7 to 2.8 million individuals. Consistent with New York State's efforts to promote the maintenance of Medicaid eligibility even after cash assistance is no longer being received, the number of individuals in receipt of Medicaid only has increased substantially and now represents over **40%** of all individuals enrolled in the program.

D. The Health Care Reform Act of 2000: Reaching Out to the Uninsured

Low-income adults often have the greatest struggle to find affordable and accessible health care. Working in lower paying jobs where benefits are often not offered, or are beyond the ability of employees to purchase, this group is at risk of untoward health outcomes and inappropriate use of medical services in clinic and hospital settings.

As the result of a broad-based consensus recognizing the issue of the uninsured, landmark New York State legislation, the Health Care Reform Act of 2000 (HCRA 2000) was passed in December 1999. This legislation established two new programs to address the needs of the uninsured, working poor: FHPlus and Healthy New York. Both programs seek to provide affordable, insurance-based health care coverage for individuals and families who now cannot access health care coverage. The programs are funded with a combination of a portion of the Tobacco Settlement Fund and other New York State support. Combined, the two programs seek to expand availability of

insurance to families and individuals with income levels up to 250% FPL. Appendix 1 provides the sections of the HCRA 2000 legislation authorizing FHPlus, together with recent amendments which are pending signature by the Governor.

1. Family Health Plus

FHPlus expands eligibility in the Medicaid program, building on the SCHIP insurance model, **so** low-income, working parents can also have coverage. FHPlus would also cover adults without children who lack health coverage. Care is to be provided through managed care plans, with a modified benefit package closely aligned to CHPlus benefits. Through expansion of the Medicaid program to include this group, FHPlus would cover additional low-income adults with or without children.

New York State's FHPlus program closely parallels the federal "FamilyCare" program introduced in January 2000 by providing a package of services similar to SCHIP for low-income adults. In addition, the FHPlus proposal will begin to address other key federal initiatives including simplification of Medicaid enrollment, and expanded sites to enroll individuals in SCHIP and Medicaid. The expanded outreach capacity under FHPlus should also serve to accelerate enrollment of uninsured children in Medicaid and CHPlus.

2. Healthy New York

Healthy New York is a New York State funded program designed to encourage small employers to offer health insurance coverage to their employees. It will also make coverage available to uninsured employees whose employers do not provide group health insurance.

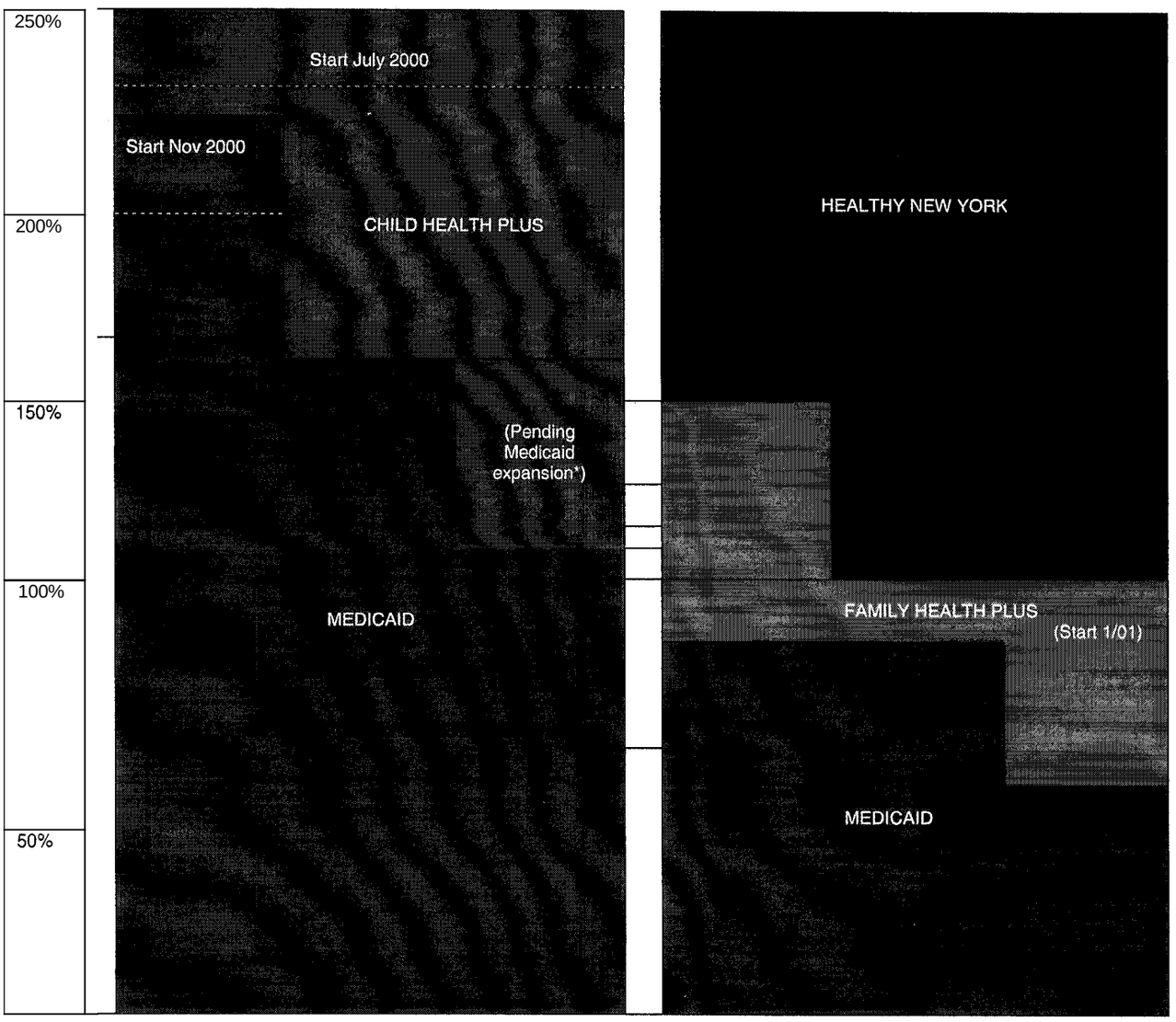
Healthy New York creates a standardized benefit package which all State health maintenance organizations must offer. This package will be more affordable than current health insurance options through State funding of stop **loss** claims and modifications and limits to coverage.

The Healthy New York service package, while providing all core ambulatory and acute care services, is somewhat reduced from existing State mandates governing health insurance policies, and includes some additional limits on benefits. This less expensive service package, combined with State reimbursement of stop loss claims, will have a favorable impact on the premium rates for these products, and make them more affordable for both individuals and small employers. Administered by the State Insurance Department, this program will be available to eligible businesses and direct pay individuals with incomes up to 250% of FPL. Over $200 million in State funding has been allocated for the program over two and one half years.

Figure I provides a schematic of coverage for low-income New Yorkers when FHPlus and Healthy New York are available. These key additions, combined with

REACHING THE UNINSURED USING FAMILY HEALTH PLUS

Note: Income eligibility levels are applied as either net or gross. For purposes of comparison, all income levels are expressed as gross or gross equivalent.



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pending changes to Medicaid and CHPlus, dramatically expand the availability of health insurance in New York.

E. Purpose and Outcomes of the Demonstration Amendment

The major goal of FHPlus is to improve the health of uninsured adults with incomes somewhat in excess of the current Medicaid level, while maintaining fiscal integrity. Other outcomes include:

- Supporting the goals of welfare reform by assuring that employed individuals are able to continue working with adequate health insurance.
- Testing the effectiveness of the CHPlus service package for adults.
- Promoting health insurance as an item that is obtained for a family as a whole, rather than only individual members of a family.
- Assuring seamless transitions for individuals between and among the CHPlus, Medicaid, FHPlus and Healthy New York health insurance programs.
- Identifying and testing means to streamline obtaining and maintaining eligibility in publicly funded programs, and to transition New York State Medicaid from a perceived "welfare" support to a health insurance program.
- Assuring that individuals and families seeking health coverage are given the opportunity for a "full" Medicaid determination.

F. Relationship to Partnership Plan

The original Partnership Plan 1115 waiver has allowed New York State to redesign its health care system for the poorest and most at risk. FHPlus is a means to strengthen and expand the Partnership Plan 1115 waiver by:

- Providing access to health care coverage for additional low-income New Yorkers who have no other options for health coverage.
- Continuing to reorient the service delivery system of the State to cost effective, high quality managed care.
- Avoiding costly inpatient interventions through the expanded use of primary and preventive care.
- Seeking to improve the health outcomes of additional New Yorkers who have slightly higher incomes due to employment.

By building on the current waiver and integrating the experience and successes of the CHPlus program, this amendment will further the goals of the original Partnership Plan, while building an integrated publicly funded health care system. This proposal seeks to build upon the best features of traditional Medicaid and SCHIP, build an accessible health care system for families and individuals, and meet the key federal objectives of consumer protection, quality of care and cost effectiveness. The waiver amendment will also provide HCFA the opportunity to test critical questions about low wage earners in the workforce, either newly employed or long term, who cannot otherwise access health care.

This amendment offers a unique opportunity to strengthen and expand the current demonstration to serve more individuals who are in need of health care, and have no means to get coverage. The following chapters provide detailed information about the proposed FHPlus program, and its integration into the existing waiver. The proposal includes requests for amendments to the terms and conditions, **as** well as budget neutrality computations, in order to accommodate the features of FHPlus included in New York State legislation.

CHAPTER TWO: DEMONSTRATION DESIGN

A. Introduction

Having strengthened the Medicaid delivery system for adults, expanded Medicaid eligibility levels for most individuals leaving the public assistance system, and implemented a comprehensive insurance coverage program for low-income children, New York State now seeks to address the needs of low-income uninsured adults. This waiver amendment will, therefore, expand Medicaid coverage to new groups of low-income uninsured New Yorkers including:

- Individuals and families, with incomes or assets above the current Medicaid levels, who are working in jobs where benefits are not available or are unaffordable.
- Parents who have exhausted eligibility under **TMA.**
- Individuals and families who qualify for Medicaid only after incurring medical bills equal to income above the applicable Medicaid level ("spend down").

FHPlus' design seeks to assure maximum participation by:

- Streamlining the eligibility and enrollment process to assure continuous and coordinated health coverage.
- Easing the eligibility determination process by using enrollment facilitators who will guide applicants through the process.
- Strengthening outreach efforts to identify and enroll potential eligibles to ensure that eligibles do not "fall through the cracks."

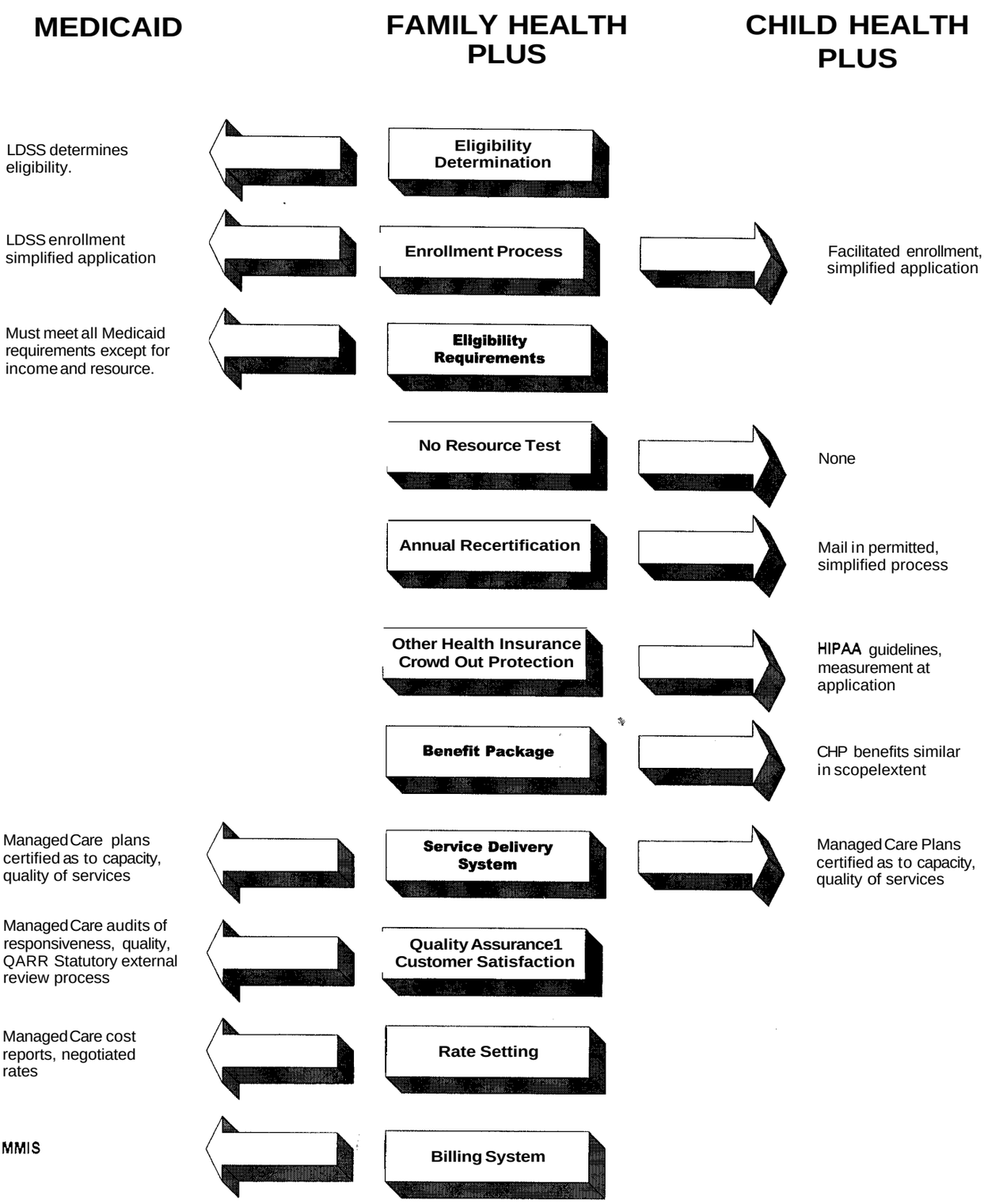
As described in the following section, FHPlus is designed to apply the best features of Medicaid and CHPlus to reach the uninsured, while maintaining fiscal integrity. Figure 2 provides an overview of key aspects of FHPlus and the program on which they are modeled.

B. Eligibility for Family Health Plus

Consistent with the FHPlus legislation, individuals who meet the following criteria are eligible to enroll in FHPlus:

Figure 2

FAMILY HEALTH PLUS
USING THE BEST OF CHILD HEALTH PLUS AND MEDICAID



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- Permanent residents of New York State.
- Age 19 through **64.**
- Citizen or eligible qualified alien pursuant to PRWORA.
- Not eligible for Medicaid based on income and/or resources.
- Not in receipt of "equivalent" health care coverage or insurance.

Parent(s) living with a child under the age of 21 will be eligible if the gross family income is up to:

- 120% of the FPL as of January 1, 2001;
- 133% of FPL as of October 1, 2001; and
- 150% of FPL as of October 1,2002.

Individuals without dependent children in their households will qualify with gross incomes up to 100% FPL, as of January 1, 2001.

New York State is requesting a waiver of any applicable statutes and regulations to accommodate these eligibility standards, and provide federal financial participation for these groups.

I. Assessing Eligibility

While we expect that the majority of FHPlus applicants will use the facilitated enrollment process, local districts will also be trained in FHPlus and will be able to determine eligibility for the two programs. Persons who qualify for the existing Medicaid program are ineligible for FHPlus. To ensure that individuals applying for FHPlus are aware that they may also be eligible for New York State's existing Medicaid program, and vice versa, the eligibility review process will combine determinations for both Medicaid and FHPlus. Vigorous standards will be maintained to assure that applicants eligible for traditional Medicaid are enrolled in that program. Local districts will make the final determination whether the applicant qualifies for Medicaid under current rules and, if not, whether the applicant is eligible for FHPlus

2. Household Size

The definitions of household size and countable income will be consistent with the Medicaid and CHPlus programs to the extent possible. Recent refinements in household definitions undertaken to develop the joint CHPlus/Medicaid application process will be adopted by FHPlus.

3. Income and Resources

Income eligibility for FHPlus will be determined on the basis of the family's gross income. A step-by-step screening worksheet will be used to assess whether or not the applying household is eligible for Medicaid or FHPlus based on income. In

addition, our Electronic Eligibility Decision Support System (EEDSS), an automated system to ease the process of interviewing and gathering eligibility information, is being implemented in local districts. It is our expectation that we will adjust the system to reflect FHPlus requirements.

Eligibility for FHPlus will not include a resource (asset) test. However, asset information will be collected in order to screen for Medicaid eligibility. If the total assets declared by the applicant exceed the asset limits allowed by Medicaid, asset documentation will not be required and the individual or family will be tested for FHPlus eligibility. An attestation that the assets are above the Medicaid level will be used when the applicant's income exceeds the Medicaid level.

If the reported assets are below the Medicaid resource standards, the individual/family will be encouraged to apply for Medicaid using the same application form. The application and all supporting documentation will be forwarded to the local district for a final determination of Medicaid eligibility. Applicants using the attestation will be informed that they are entitled to a traditional Medicaid determination and an explanation of the need for additional information to complete that process.

Waivers are requested to implement the income levels, lack of resource test, and lack of income disregards which are defined in FHPlus legislation.

4. Non-Financial Requirements

Generally, the non-financial requirements for FHPlus will parallel the requirements for AFDC-related Medicaid, where applicable. Recognizing that the sometimes difficult process of collecting documentation may result in an incomplete application, New York will use facilitators to help families obtain required documentation, as well as explain to families the types of documents that will satisfy the requirements. Applicants and enrollees for FHPlus will be asked to provide the following information, when appropriate:

- Social security numbers for all family members of the household who are applying for FHPlus.
- Verification of information concerning age, identity, residency, citizenship/-alien status and relationships within families.
- Income verification - the most recent form of income documentation available, that accurately represents the current financial status of the family, will be used to determine eligibility.
- Verification regarding the source and scope of any health care coverage the person is receiving.

New York State will utilize existing Medicaid computer matching operations to verify health insurance and financial information for applicants for FHPlus.

5. Current Insurance and Crowd Out

a. Current Insurance

As with the CHPlus program, persons who are covered by a health insurance plan that meets the Health Insurance Portability and Accountability Act (HIPAA) standards are not eligible for FHPlus. See Appendix 2 for specific guidelines to be applied. New York is requesting a waiver in order to allow only those without insurance to be enrolled in FHPlus.

b. Crowd Out Prevention

Similar to CHPlus, New York will monitor whether FHPlus causes reductions in available health coverage by employers. Information regarding any prior health coverage will be collected at application and tracked to determine if changes in availability are occurring. Consistent with the FHPlus legislation, if crowd out occurs, a new eligibility standard will be applied to provide that applicants are ineligible if they had group health insurance during the six months prior to application. Certain exceptions to this limitation apply, such as:

- Loss of employment due to factors other than voluntary separation.
- Death of a family member which results in termination of the applicant's coverage under a group health plan.
- Change to a new employer that does not provide an option for comprehensive health benefits coverage.
- Change of residence so that no employer-based coverage is available.
- Discontinuation of health benefits to all employees of the applicant's employer.
- Expiration of coverage under Consolidation Omnibus Budget ReconciliationAct (COBRA).
- Termination of comprehensive health benefits coverage due to long-term disability.
- Loss of employment due to the need to care for a child or a disabled household member or relative.
- Reduction in wages or hours or an increase in the cost of coverage so that coverage is no longer affordable or available.

New York believes that the crowd out measurement methodology will allow effective monitoring of the impact of FHPlus on private health insurance. The New York State CHPlus program has applied this criteria for two years and, to date, has not needed to impose new eligibility criteria as a result of crowd out.

6. Other Medicaid Standards

a. Parental/Spousal Support

Applicants for FHPlus will be required to cooperate with federal support requirements concerning the establishment of support liability of legally responsible relatives and child support.

b. Guaranteed Six-Month Eligibility

All newly eligible persons who are initially enrolled in FHPlus will be entitled to six months of guaranteed coverage.

c. Retroactive Coverage

Because FHPlus will utilize a managed care service delivery system, without fee-for service, there will be no retroactive coverage. In instances where persons indicate a need for assistance to pay for medical expenses incurred during the three-month period prior to the month of application, a referral will be made to the local district to have their Medicaid eligibility assessed for the appropriate period. Medicaid will be granted for any portion of that three-month retroactive period for which the applicant is determined eligible. New York State is requesting a waiver of the three-month retroactive eligibility requirement for the newly eligible FHPlus populations.

d. "Spend Down" Population

Applicants who are eligible for both FHPlus based on income, and spend down provisions under traditional Medicaid, will be given the option of participating in FHPlus or receiving full Medicaid benefits. (Under the New York Medicaid Surplus Income Program, participants in the traditional Medicaid program can become eligible through spend down either by submitting proof of medical expenses or "paying in" the amount of excess.) The services available under both FHPlus and traditional Medicaid will be fully discussed with these individuals and families to ensure an informed choice is made. Counseling will be provided to assure that the applicants' decision provides the services they need, and minimizes their out-of-pocket expenses. Individuals in need of services such as long term care, which are not covered by FHPlus, will be enrolled in traditional Medicaid.

e. Fair Hearings

The current system of fair hearings for eligibility determination will be extended to FHPlus applicants/recipients to ensure that they are treated in a fair and equitable manner. Appeals regarding FHPlus eligibility will be handled by the State and local districts, in accordance with federal and State requirements.

Generally, health coverage under FHPlus will continue for enrollees during an eligibility appeal which results from FHPlus disenrollment.

C. The Family Health Plus Service Delivery System

New York State statute delineates, except in the limited circumstances described more fully below, that FHPlus services be provided by managed care organizations. Consistent with this directive, the New York State Department of Health (DOH) will select FHPlus plans from among currently approved CHPlus and Medicaid managed care plans which are actively serving these populations. Existing plans have established their ability to meet quality standards, and maintain accessible provider networks and have established linkages with specialty care providers. The use of these plans for FHPlus will ease administration, and provide both continuity and high quality of care.

1. Plan Availability

New York State has an extensive network of health plans serving CHPlus and Medicaid managed care. A current analysis shows that there are 37 unduplicated insurers who underwrite full risk managed care plans for the CHPlus and/or Medicaid managed care plans in New York State's 62 counties. Over 70% of these insurers participate as both Medicaid and CHPlus managed care plans, providing a large pool of potential FHPlus plans. The very large majority of these insurers (90%) provide services in more than one county.

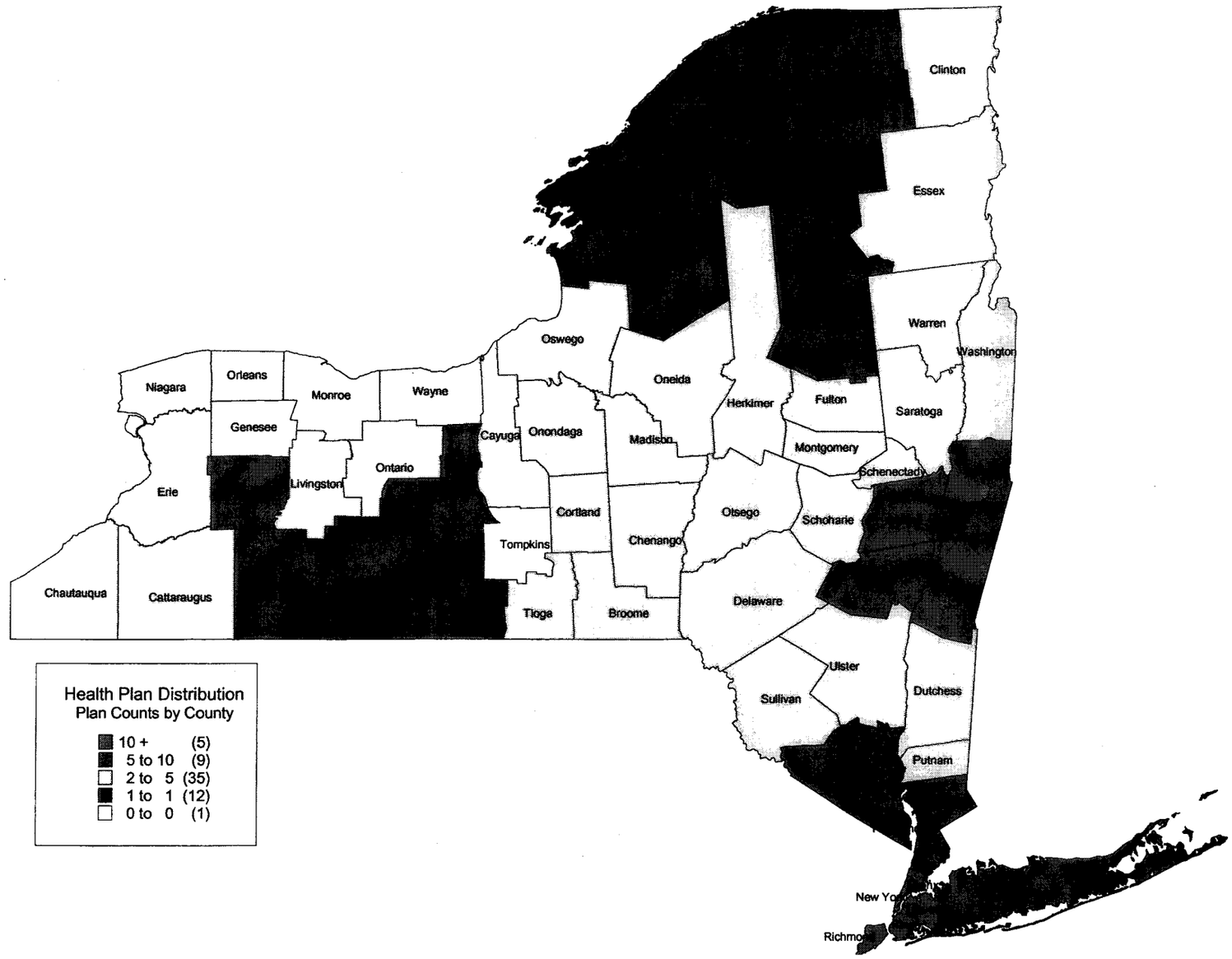
An analysis of current plan locations illustrates the availability of an adequate number of plans throughout New York State (see Figure 3). If sufficient statewide access cannot be assured through the initial recruitment of participating plans, additional plans could be recruited based on the following:

- There are 20 counties where Medicaid managed care plans are qualified for the Partnership Plan, but are not currently under contract.
- Medicaid managed care plans in the process of having a service area expansion approved could increase access in **28** counties.
- CHPlus plans, which are not managed care plans, but which provide a prepaid benefit package, may be recruited.

Although the DOH will pursue plan participation to assure multiple plans Statewide, a waiver is requested to not require that two or more plans be available in each county. FHPlus is a voluntary, not mandatory program, and there is no fee-for-service alternative available for enrollees. Those applying have no other options for care, and should not be excluded from access to health care because there is only one plan participating. Our analysis shows that currently there are 12 counties with only one full risk managed care insurer servicing Medicaid and/or CHPlus enrollees. Population statistics show that only 3% of the population resides in these counties. As these are areas that tend to have lower wages and potentially the lack of

Distribution of DOH Managed Health Plans by County

Figure 3



employer insurance, such as the Adirondacks and upstate rural areas, FHPlus could provide the only alternative for health care, as is the case for CHPlus. We are awaiting final rules to be released by HCFA regarding this issue which may address the problem.

New York is also proposing that the issue of plan choice be examined through this demonstration. In counties where selection is limited to one plan, New York will be able to measure the satisfaction level of enrollees in counties with one plan compared to participants residing in multi-plan counties. The resulting information will be helpful in guiding policies and practices regarding plan choice.

2. Selection of Participating Plans

A Request for Application (RFA) for plans to participate in FHPlus will be issued to organizations currently approved as Medicaid managed care or CHPlus plans. Applicants will be evaluated using existing information gathered by the DOH regarding their current quality assurance and financial performance as CHPlus and Medicaid managed care plans. Additional information will be requested regarding specific areas due to program and population differences (member services, network composition, capacity to accommodate the new population and any financial status changes since DOH's last survey). While local districts will have input into the selection criteria and review process, the successful plans will contract directly with the DOH. Based on information from the plan associations, it is anticipated that there will be a high plan response rate.

3. Access in Areas with Limited Plan Availability

In areas of New York State that do not have sufficient FHPlus managed care access, the FHPlus statute authorizes the DOH to contract with commercial insurers who have been approved to underwrite a prepaid benefit package covering the services available under FHPlus. For example, in Tompkins County (population 94,000) in Central New York, the only health plan currently available delivers this type of insurance product for the CHPlus program. (There is no Medicaid managed care plan in operation at this time in Tompkins County.)

D. The Family Health Plus Benefit Package

FHPlus will provide a comprehensive set of benefits to individuals who otherwise have no access to health care coverage. The benefit package to be offered is outlined in State statute and modeled on the New York State's CHPlus program, which includes primary, preventive and inpatient care. The benefits design is closely aligned with commercial insurance and employer plans, including the New York State employee insurance program.

1. Covered Services

The FHPlus benefit package will include:

- Physician services;
- Inpatient and outpatient health care;
- Prescription drugs;
- Smoking cessation products;
- Lab tests and x-rays;
- Vision care;
- Speech and hearing services;
- Durable medical equipment;
- Home health services (short term, acute care in lieu of hospitalization, up to 40 visits per year);
- Family planning services and supplies;
- EPSDT services;
- Emergency room services;
- Emergency ambulance transportation;
- Inpatient mental health and alcohol and substance abuse treatment (30 days per year);
- Outpatient mental health and alcohol and substance abuse services (60 visits per year);
- Diabetic supplies and equipment;
- Radiation therapy, chemotherapy and hemodialysis; and
- Dental services (to the extent offered by the plan).

2. Services Not Included

Non-covered benefits and exclusions are consistent with policies generally provided by commercial health insurance companies and employers. Long-term care services for the chronically ill including nursing home, home attendant, hospice, Intermediate Care Facilities for the Developmental Disabled (ICF/DD) and private duty nursing will not be covered. Non-emergency transportation, medical supplies and non-prescription medications, except for smoking cessation products, will also be excluded. Benefit limitations, where applicable, will be defined consistent with CHPlus.

Figure 4 provides a comparison of traditional Medicaid, CHPlus and FHPlus covered benefits, highlighting the comprehensive benefits provided.

3. Carve Out and Wrap Around Services

Currently, Medicaid managed care "carves out" certain services from the capitated payment, which are available to the recipient on a fee-for-service basis. The services identified and defined in the FHPlus benefit package represent the

SERVICE COMPARISON

Federally Mandated Services	MA	CHP	FHP
Inpatient Hospital	Y	Y	Y
Outpatient Hospital	Y	Y	Y
Physician Services	Y	Y	Y
Medical and Surgical Dental	Y	Y	Y
Nursing facility (21 and older)	Y	N/A	N
Home Health Services	Y	Y*	Y*
Medical Supplies	Y	N	N
Durable Medical Equipment	Y	Y	Y
Family Planning Services and Supplies	Y	Y	Y
Rural Health Clinic	Y	Y	Y
Lab	Y	Y	Y
X-ray	Y	Y	Y
Nurse Practitioner	Y	Y	Y
FQHCs	Y	Y	Y
Midwife	Y	Y	Y
EPSDT	Y	Y	Y
Medicare co-insurance and deductibles for QMBs for chiropractors, podiatrists, portable x-ray and clinical social work	Y	NIA	N/A

Federally Optional Services	MA	CHP	FHP
Freestanding clinics	Y	Y	Y
Nursing Facility for<21	Y	N	N
ICF/DD	Y	N	N
Optometrist and eyeglasses	Y	Y	Y
Prescription Drugs	Y	Y	Y
Therapeutic Services - PT/ST/OT	Y	Y	Y
Dental Services	Y	Y	Y*
Audiology and hearing aids	Y	Y	Y
Clinical Psychologist	Y	Y	Y
Private Duty Nursing	Y	N	N
Diagnostic, screening, preventive and rehabilitative services	Y	Y	Y
Personal Care	Y	N	N
Non-Emergency Transportation	Y	N	N
Emergency Transportation	Y	N**	Y
Hospice	Y	N	N
Case Management	Y	N	N
Inpatient Psychiatric Care	Y*	Y*	Y*

*Some Limits Apply
** Change anticipated to include this service

complete services available. Consistent with New York State's CHPlus program, FHPlus will offer a managed care model with a fully capitated rate for all FHPlus covered services, without carve outs or fee-for-service wrap around services.

4. Other Service Issues

a. Family Planning Services/ Women's Health Care Specialty Services

Consistent with both the CHPlus program and commercial insurance offerings, FHPlus enrollees will be allowed direct access to family planning services or women's health specialty services in the following manner:

- FHPlus enrollees will be allowed to select, without a referral from their primary care provider, a family planning service provider from within the plan's network.
- If a FHPlus plan elects not to cover the family planning benefit directly, a separate contractual arrangement will be made by the State for the provision of these services.

Again, a FHPlus enrollee would not need a referral from their primary care provider in order to access these services. Enrollees will receive full information about their rights, and how and where to obtain these services.

The DOH will evaluate plans during the selection process specifically to assure that access is available for these very important special services.

b. Emergency Care and Services

Health plans are prohibited from requiring enrollees to seek prior authorization for services in a medical or behavioral health emergency. Enrollees will be informed that access to emergency services, using the prudent lay person's definition of an emergency condition, is unrestricted, except that plans may require enrollees to notify them within a 24-hour period of the occurrence of the emergency.

Emergency ambulance service will be covered for FHPlus enrollees who require emergency medical care en route to receiving emergency care at a hospital. The prudent layperson's definition of an emergency condition will be used as a guideline for plans in determining the medical necessity of an emergency ambulance transport.

c. Special Needs Plans (SNPs)

SNPs were proposed under the current Partnership Plan to address the intensive and complex service needs of a small percentage of Medicaid enrollees who require high intensity, specialized services and case management. The

special needs plans utilize service packages and networks which are designed specifically to meet the needs of these individuals.

Most individuals with this level of need would be Medicaid eligible and thus, not be eligible for FHPlus. Moreover, the FHPlus benefit package may not include the level of service required by those who need specialized and intense treatment. As a result, FHPlus will not include such specialized plans. However, the plans that are operating SNPs are eligible to become participating FHPlus plans, providing the FHPlus benefit package.

E. Rate Setting for Family Health Plus

FHPlus plans will be reimbursed a monthly capitation rate for the comprehensive set of services included in the benefit package. Actuarially sound rates will be established using a budget actuarial method based on the existing Medicaid managed care rate setting process. As part of the RFA process, each plan will submit a premium rate proposal based on projected utilization and unit cost of medical services and administrative costs. Final premium rates will be negotiated between the DOH and the FHPlus plan. Separate premium groups will be established for FHPlus. With the advice of the DOH's consulting actuary, premium groups may be risk-adjusted based on the geographic location, age and/or gender of the members.

F. Application and Enrollment Process

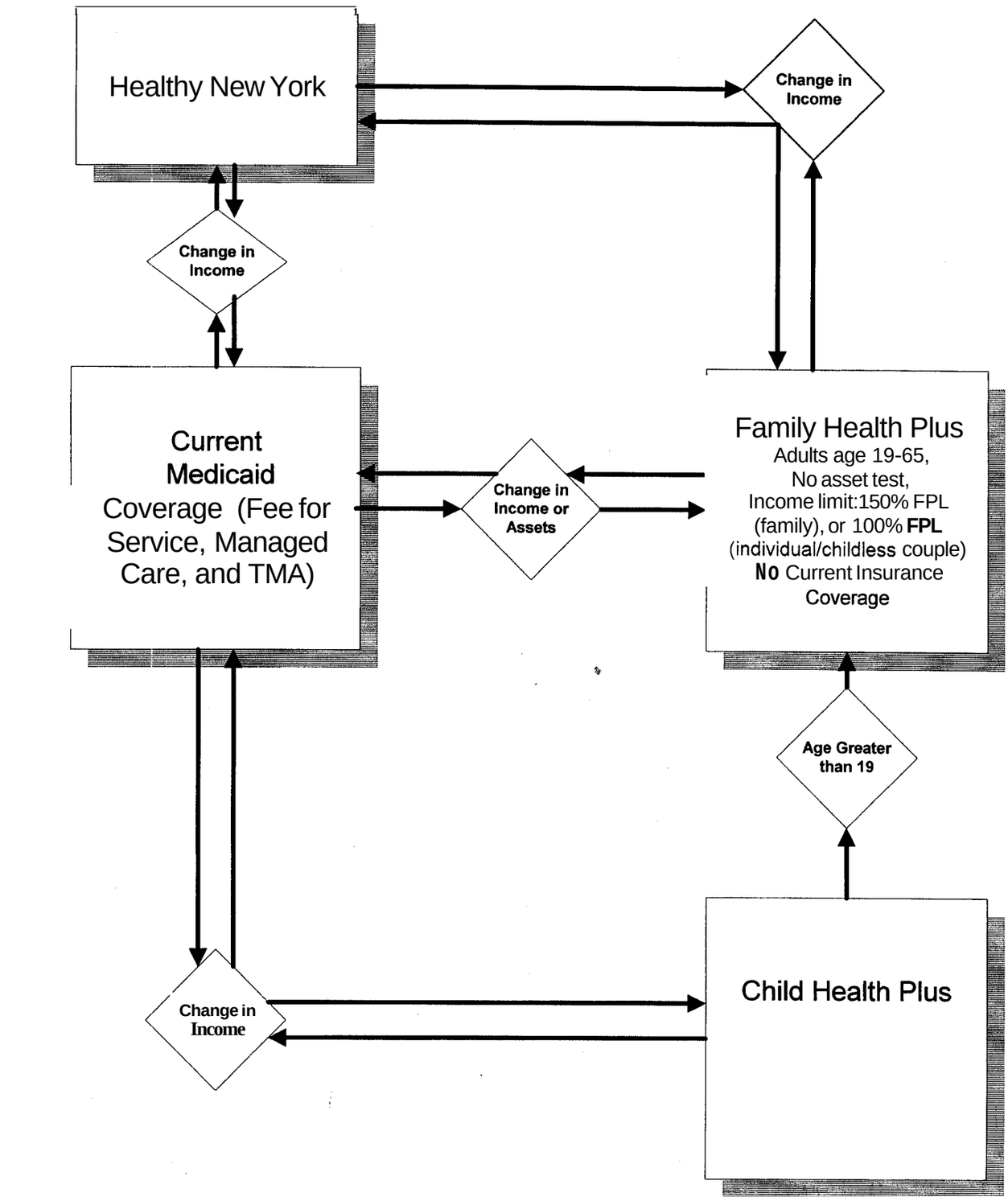
FHPlus application and enrollment processes are designed on the basis of the successful CHPlus model, which includes community-based facilitated enrollment , a joint application for all public insurance options, counseling, and a simplified application form. This approach will increase access, coordinate family coverage and streamline the review process.

G. Coordination with Other New York State Health Insurance Options

An essential component of the waiver amendment is not only to expand coverage to new enrollees under FHPlus, but also to ensure full integration of the new program into existing public insurance coverages. Without alignment and coordination, the Medicaid system will become more difficult to maneuver, and FHPlus will not meet the objectives of expanding coverage availability. At each point of potential transition to and from each of the key program areas, efforts are being made to assure continuation of coverage and consistent access to health care services. Figure 5 presents a diagram of potential transitions between and among FHPlus, traditional Medicaid, CHPlus and Healthy New York.

Through the development of an integrated and streamlined approach to the application and enrollment processes, consistency of program guidelines and definitions, and eligibility systems integration, participants are more likely to receive continuous and coordinated health care coverage. New York State has already

Transitions Between Health Insurance Coverage:
Points to Assure Continuous Coverage



undertaken steps to initiate system enhancements to both the Welfare Management System (WMS) and Medicaid Automated Budget Eligibility Logic (MABEL) which will provide for the integration of FHPlus and Medicaid.

Efforts will be made to enroll former Partnership Plan recipients in the same plan under FHPlus when they become eligible. This will allow enrollees to move from one program to another while continuing to remain with the same managed care organization and continuing to see the same health care providers. Former Medicaid recipients who received Medicaid on a fee-for-service basis, but who qualify for FHPlus, may be assisted with plan selection by either the local district or an enrollment facilitator. Counseling will be provided to maintain primary care continuity.

2. Facilitated Enrollment

The FHPlus legislation seeks to reduce some of the barriers which are known to discourage individuals and families from seeking Medicaid coverage. Building on the recent implementation of CHPlus facilitated enrollment, FHPlus will also seek to provide a positive experience for all children and adult applicants for health care coverage.

An expanded system of community based enrollment assistance will be built for FHPlus **so** that individual and family applicants for health insurance can easily enroll in FHPlus, CHPlus and Medicaid in a timely, coordinated and user friendly fashion. Using the experience of the CHPlus program, this system will ensure a consumer oriented entry, and make certain that transitions between Medicaid, CHPlus and FHPlus occur as smoothly as possible. To the extent possible, such transitions will result in no interruption of care, and maintenance of the same health care provider.

Facilitators will become the focal point of information for individuals and families seeking health care coverage. They will assist individuals and families complete a combined application for Medicaid, FHPlus, CHPlus, and WIC. This assistance will include screening the family for the appropriate program, completing the application, assisting in the collection of the various documentation items, and counseling for plan selection.

To maximize enrollment in FHPlus and eliminate the stigma associated with public programs, potential applicants will be able to apply at sites other than the local district office. These sites will include various locations that are convenient for the target group, and could include clinics, churches, food banks, YMCA/YWCA, BOCES, shopping centers and supermarkets, Salvation Army sites, day care centers, one-stop career centers, libraries, community action agencies and other community locations. To accommodate working families, facilitators will be available during hours convenient to their work schedule, such as evenings and weekends. Through the facilitated enrollment process, no face-to-face interview will be required at the local district.

3. Training

The training of organizations selected as lead agencies and community based facilitators will be provided by a private vendor to be selected by New York State. To accommodate the new volume of applicants, existing CHPlus agents will be expanded through a procurement to include selected new lead community organizations and local facilitator groups. Regional training sessions will be required throughout New York State to ensure that facilitators have the necessary knowledge, training and sensitivity.

Facilitators will also be responsible for referring applications by eligible children to WIC and for referring adults who are ineligible for FHPlus and Medicaid to the Healthy New York program. Training will be provided on the complaint process and facilitators will be able to assist members in filing complaints either with the plan or with the local district.

Along with facilitators, local district staff will receive training on the following:

- FHPlus eligibility including the use of the eligibility screening tool and new application form.
- FHPlus enrollment policies and time frames.
- Enrollees' right to confidentiality.
- Communicating with special needs populations.
- How to access services under managed care.
- Assisting new eligibles in making informed choices (criteria to consider in selecting a plan).
- Plans available under FHPlus and their network composition.
- Procedures for filing a complaint and/or appeal.
- The recertification process.

Special training will also be provided to ensure that facilitators and local district eligibility workers are proactive and offer all applicants the opportunity to apply for all programs for which they may qualify.

4, Simplified Application Form

New York State recently developed a new single application for children, called Growing Up Healthy, to use in the eligibility review for the Medicaid, CHPlus, Health Plus and WIC programs. The new application is included as Appendix 3. Through an extensive developmental process, progress was made in simplifying and coordinating definitions, rules and requirements for these programs. This application form will be adapted to include FHPlus to enable the entire family to be assessed for eligibility determinations, and to ensure that individuals and families receive services through the "right door."

Figure 6 below provides a comparison of key eligibility factors across programs which will be incorporated into the combined application.

Figure 6

ELIGIBILITY FACTORS FOR HEALTH INSURANCE PROGRAMS

Eligibility Factor	Children's Medicaid	Child Health Plus	Adult MA	Adult FHP
Home Address	✓	✓	✓	✓
Age	✓	✓	✓	✓
Family Income	✓	✓	✓	✓
Household Size	✓	✓	✓	✓
Other Insurance		✓		✓
Assets/Resources			✓	
Immigration Status	✓	✓	✓	✓

5. Recertification

Recertification will be simplified by the assistance provided by enrollment facilitators and elimination of the face-to-face interview at the local district office for FHPlus enrollees. Changes in participant circumstances will be identified through annual reviews via a shorter, simpler recertification form which the enrollee will be able to submit by mail.

Information requested at the time of recertification will be limited to those items that are subject to change, such as income, resources, other coverage and residency. In cases where an individual reports a change in circumstances, only an assessment of the factors affected by the changed circumstances will be examined.

Plans will be notified of the recertification dates of their FHPlus enrollees in order to assist in completion of the process in a timely manner. Families may recertify by mailing the recertification information to the local districts, but the local district will also provide locations and hours of facilitators to assist in the recertification process.

To ensure continuity of care, FHPlus individuals and families who report a change in circumstances, and who appear to be eligible for full Medicaid coverage, will stay covered under their FHPlus plan until the Medicaid determination is made by the local district. Moreover, in other cases where continuation of FHPlus is not permitted, efforts will be made to direct a FHPlus individual to other types of assistance (i.e. Healthy New York and Medicare) so that the most comprehensive health care coverage can be obtained.

Enrollees will no longer be eligible for FHPlus when:

- They reach the age of 65.
- Their gross income exceeds the FHPlus eligibility criteria.
- They become eligible for Medicaid under "spend down" provisions AND indicate a preference to receive Medicaid as a fee-for-service spend down recipient.
- They obtain "equivalent" health insurance coverage.
- They become eligible for full coverage under Medicaid.

6. Plan Enrollment and Primary Care Physician Selection

a. Plan Enrollment

Facilitators will assist FHPlus applicants in choosing a FHPlus plan, and a primary care physician (PCP). They will inquire as to existing provider relationships, in an effort to identify health plans in which an individual's/family's current provider(s) participates. To allow applicants to make an informed choice of which plan will best meet their needs, the facilitator will be responsible for providing complete and impartial information about all participating insurers. Enrollment in the selected plan will be completed by the local district, after confirmation of FHPlus eligibility.

Although efforts will be made to ensure that FHPlus members have access to the same plans as other household members (if available under FHPlus), individuals of the same family household will not be required to enroll in the same plan as other FHPlus, CHPlus or Medicaid managed care members.

Individuals will select a FHPlus insurance plan from among those qualified plans that are approved under the FHPlus program at the time of application or recertification. New York is proposing to use a 12-month lock in period for enrollees who have indicated their plan selection. Once a selection is made, enrollees will still be permitted to change plans during a 90-day "grace period."

Because enrollment in FHPlus is voluntary, auto-assignment to a plan will not be utilized. If an applicant, despite counseling and reminders, does not choose a plan, the application will be considered incomplete.

b. Plan Initiated Disenrollment

Plan initiated disenrollment will be limited to circumstances where there is clear and consistent documentation that the individual's behavior is verbally or physically abusive and/or causes harm to other enrollees or to the plan providers and staff. Disenrollment may not be initiated due to an enrollee's refusal to accept a specific treatment or for behavior resulting from an underlying medical

condition, alcohol or substance abuse, mental illness, mental retardation or other developmental disability.

A plan will also not be permitted to disenroll a participant based on the participant's diagnosis, condition, or perceived diagnosis or condition or a participant's efforts to exercise his or her rights under a grievance process. A plan will not be permitted to disenroll a participant without the permission of the local district in which the member resides.

c. Primary Care Physician Selection

Enrollees will select a PCP from among those participating in the plan's network. Members will be allowed the freedom to change PCPs within 30 days after their initial contact with the PCP, with or without good cause. After the first 30 days, members may change their PCP selection every six months without cause.

G. Other Family Health Plus Features

1. Cost Sharing

FHPlus enrollees will not be required to pay any co-payments, premiums or deductibles. This policy is also consistent with New York's policy for the Medicaid managed care population under the Partnership Plan, as well as low-income enrollees in CHPlus.

2. Identification Cards

Plans will be responsible for issuing identification cards to FHPlus enrolled members. Plans will be prohibited from using identification cards for FHPlus which are substantially different than those used for commercial populations.

3. Notices

Notices will be sent in a timely manner and contain information on the member's right to file a complaint or appeal regarding an adverse eligibility decision by the local district in concert with DOH. Local districts will be responsible for ensuring that FHPlus applicants and members receive:

- An initial notification letter informing the applicant of approval/denial of eligibility for FHPlus. This letter will include the applicant's/member's rights and responsibilities under FHPlus.
- A discontinuance notification letter informing the applicant/member that he or she is no longer eligible for FHPlus. This letter will also include information on the member's rights to appeal the agency decision as well as information

about other health insurance options that may be available, such as the Healthy New York program.

- A recertification notification informing the member that eligibility for continued FHPlus will need to be redetermined.

H. Outreach and Publicity for FHPlus

New York State will develop a comprehensive plan for FHPlus outreach that will complement and build upon the efforts currently in place for the CHPlus program. Many of the same successful strategies used to promote the CHPlus program will be used to support and promote FHPlus.

1. Statewide Outreach and Education

New York State plans to promote FHPlus as a health insurance program for low-income individuals/families through a variety of Statewide outreach and marketing activities. Funding will be made available to develop materials and advertising to reach potentially eligible populations. Community based organizations (CBOs) will be responsible for the distribution of brochures and fliers through the mail or directly through local health centers, churches, and other community institutions. Statewide publicity will include billboards and posters in places frequented by low-income adults and working with CBOs to develop other creative outreach programs.

FHPlus outreach will also include special promotional events at health fairs, and multi-media campaigns, including print, radio and television advertising. Such campaigns will generate public awareness about health insurance coverage and promote enrollment in both FHPlus and Medicaid.

Written outreach and educational materials developed will include information describing the new program, who is eligible, listings of available plans and a phone number to call for additional information. All contracted marketing materials will be approved by DOH within 60 days prior to its dissemination to prospective FHPlus enrollees.

2. Outreach by Facilitators

Facilitated enrollment organizations approved for FHPlus will also be responsible for local publicity and outreach. By using a network of community organizations that are familiar with local cultures and organizations, outreach can be tailored to the needs of individual communities. All material will be approved by DOH prior to distribution.

3. Publicity by Plans

Plans who are approved for facilitated enrollment will only be permitted to market and assist participants in approved locations. Consistent with the legislation, an

emergency room will not be considered an approved location. Plans will also be prohibited from telephone cold-calling and door-to-door solicitations at the homes of prospective enrollees.

Plans will be prohibited from offering incentives of any kind to potential FHPlus participants to join a plan. All plan outreach and marketing materials will be approved by DOH prior to distribution.

4. Monitoring Education and Outreach

The DOH will be responsible for monitoring education and outreach activities to ensure that individuals are appropriately informed about FHPlus program policies. The DOH will monitor performance of the statewide toll free telephone help line and conduct a pre-implementation review of all outreach and education activities.

I. Assuring Access and Patient Rights

1. Access by Persons with Limited English Proficiency

All FHPlus applicants/enrollees with limited or no English language capabilities will be provided with translation or interpretation services, as appropriate. Participating plans and enrollment facilitators will be required to have mechanisms in place to assure effective communication with enrollees who are vision or hearing impaired, e.g., the services of an interpreter, including sign language and telecommunication devices for the deaf (TDD), as needed.

2. Access by the Disabled

FHPlus applicants/enrollees with disabilities will be afforded the protections prescribed by the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973.

3. Member Services

Plans will be responsible for designating staff who are knowledgeable with the FHPlus program to assist members with questions and concerns. Plans will provide members with a plan toll-free telephone number that may be accessed 24 hours per day, seven days per week. The effectiveness of member services will be monitored by DOH.

Plans will need to ensure that mechanisms are in place for communication with all enrollees, including the disabled and non-English speaking.

4. Member Handbook

Plans will issue a handbook to new members within **14** days of the effective date of enrollment. Member handbooks will include information regarding: services included in the FHPlus benefit package and how to obtain them; non-covered services; instructions on how to change plans; a description of the plan's complaint procedures; and, information regarding member rights and responsibilities. DOH will provide plans with a model member handbook, based on the Partnership Plan handbook, and will approve plan handbook contents.

J. Quality Assurance

New York State plans to monitor the financial performance and quality assurance activities of each FHPlus plan through the existing Partnership Plan Quality Assurance Monitoring Plan. The objective of this plan is to ensure access and, ultimately, to improve the health status of the managed care population. **As** with Medicaid managed care, the quality monitoring system for FHPlus will incorporate three major components:

- The development of internal quality improvement systems within each managed care plan;
- External monitoring and data collection activities, including routine review of HEDIS and encounter data and reports submitted by the plans, on-site operational reviews, targeted "undercover" reviews; and
- Consumer satisfaction surveys and data.

1. Internal Quality Improvement/Quality Assurance Programs

New York State will ensure that managed care plans develop internal quality improvement programs designed to promote positive health outcomes, identify problems and implement mechanisms to correct those problems, and ensure that the provision of care is consistent with generally accepted medical standards and clinical guidelines. Quality assurance guidelines will be based on the Partnership Plan standards.

2. Grievances and Appeals

The DOH will monitor complaint and appeal processes at all levels of the FHPlus demonstration. Data on general and plan-specific oral and written complaints (including complaints received through both the New York State hotline or plan helpline) will be collected and compiled according to: category of complaint, outcome and resolution time, and what corrective action steps, if any were taken. Summary data regarding complaints, appeals, and external reviews will be made available to HCFA.

FHPlus plans will be required to establish procedures to handle enrollee inquiries, complaints, grievances, and appeals. Complaint and appeal processes will be accessible to all FHPlus enrollees, including the disabled.

Generally, enrollees will be instructed to contact the plans first if they have problems related to the medical care provided. Enrollees will contact the local district for problems related to eligibility.

FHPlus members will have the right to:

- File a complaint orally or in writing regarding any dispute with a plan.
- Designate a representative to file complaints and appeals on their behalf.
- Be assured that plans will not be permitted to retaliate or take any discriminating action against them because they **file** a complaint.

Members will be notified by the plan of their right to file a complaint and of their right to appeal a complaint that is not resolved to their satisfaction. Plans that do not make timely appeal or complaint decisions with regard to FHPlus enrollees will be subject to current applicable provisions of the federal and State laws and regulations.

Members will be informed of their rights regarding complaints and appeals at several points:

- General information regarding the right to file complaints will be included in all pre-enrollment education material and will be discussed by enrollment facilitators during the face-to-face interview.
- The member handbooks will include the address and an "800" phone number to which complaints can be addressed.

DOH will require plans to submit information, on a quarterly basis, on the number of complaints and appeals, as well as the resolution of such appeals.

3. External Review Process

Under New York State law, an external review is a request that is made for an independent review of a denial of services by a plan. Reviews are conducted by external appeal agents that are certified by New York State and have a network of medical experts to review a health plan's denial of services. The DOH has contracted with the Island Peer Review Organization (IPRO) and Medical Care Management Corporation (MCMC) to serve as its independent external appeal agent.

FHPlus enrollees, as all other managed care enrollees in New York State, have the right to an external appeal when health care services are denied by the health plan on the basis that the plan determines that services are not medically necessary

or that the services are experimental or investigational. To be eligible for an external appeal, the enrollee must have exhausted the plan's internal utilization review procedures and received a final determination, or the enrollee and the plan must have agreed to waive that appeal process. Enrollees may request an expedited (fast-tracked) external appeal if the enrollee's physician attests that a delay in providing the treatment or services poses an imminent or serious threat to the enrollee's health. In these cases the external appeal agent will make a determination within three days of receipt of the request for an external review from the State. When an appeal is not expedited, the external agent will make a decision within 30 days of receiving a request for an external review.

4. Hotlines

The DOH will have available phone access to accommodate enrollee concerns and questions. Hotlines will also provide access to interpretation services through the AT&T translation services and the New York Relay services for the hearing impaired. The DOH will monitor the:

- Number of incomplete attempts and completed calls.
- Average duration of each call.
- Caller statistics, such as first call, number of unique calls, lost callers, etc.
- Average calls received per day.
- Busiest area code/regional office.
- Busiest day by number of calls.

Access through traditional Medicaid, Medicaid managed care and CHPlus hotlines will be coordinated, with cross training provided to avoid multiple referrals.

5. Consumer Satisfaction

New York State's current Partnership Plan includes a provision for a biannual satisfaction survey of Medicaid consumers enrolled in managed health care. IPRO arranges for surveys of patient satisfaction with the Medicaid managed care program through written surveys and follow-up telephone inquiries of a random sample of the member population.

New York State plans to use the existing Partnership Plan methods to measure and monitor FHPlus consumer experiences with FHPlus plans and the network of providers. The surveys will be administered to a sample of the demonstration population to evaluate their satisfaction with the program health plans and the providers.

- The impact of the FHPlus program on member access to and use of health services.
- Member satisfaction with the medical care they are receiving from FHPlus providers.

- The interpersonal aspects of the quality of health care services FHPlus members are receiving.
- Enrollee knowledge of the FHPlus program and of the plan in which they are enrolled.
- Factors which are important to selection of a health plan.
- Information pertaining to language and cultural barriers to care.

New York will continue to use standardized survey instruments used by the Partnership Plan, such as the Consumer Assessment of Health Plan Satisfaction (CAHPS).

CHAPTER THREE: PUBLIC COMMENT AND COMMUNITY SUPPORT

As noted previously, enactment of the FHPlus program was the result of an extraordinary consensus of statewide representatives from consumer advocacy groups, managed care organizations, labor, government leaders and insurance companies. Based on this unprecedented support, negotiations were completed in the Fall 1999 to design the framework for the new program and establish its parameters and operating guidelines. Governor Pataki signed the enacting legislation--HCRA 2000--to be effective as of January 2000.

The fact that the program was designed, consensus achieved and legislation adopted in a single session speaks to the strength and commitment of New York State leaders, advocates, industry and labor representatives to address the problem of the uninsured in New York State. Moreover, it is exciting that the consensus to address the issue extended to detailing the mechanisms and processes that would make this program a success. A series of letters of support from key organizations are included as Appendix **4.**

A. Gaining Feedback

To assure that this waiver request is consistent with the legislative intent and the interests of key New York State leaders, a series of meetings and presentations have been held over the past months. Large forums have been hosted by organizations such as the United Hospital Fund and Greater New York Hospital Association to assure full representation by the various interests. In addition, numerous separate meetings with individual interest groups have been held. At each session, information on proposed approaches to implementation and operations were presented, and the audience was requested to raise issues and concerns. **A** compilation of these issues has been maintained. This compilation has been critical to assuring that policy decisions on operational issues are consistent with the interests and needs of the public. Figure 7 provides an overview of the meetings held and conferences attended to date to present information on FHPlus.

FAMILY HEALTH PLUS
MEETINGS AND PRESENTATIONS TO ORGANIZATIONS

DATE	ORGANIZATION
1/27/00	New York Public Welfare Association
1/29/00	Blue Cross
2/10/00	Health Care Association of New York
2/17/00	Health Care Association of New York
2/18/00	Health Care Association of New York
3/2/00	NYS Coalition of Prepaid Health Services Plans
3/3/00	Medical Advisory Committee
3/6/00	Junior League NYS Public Affairs Committee
3/7/00	Medicaid Managed Care Advisory Review Panel
3/8/00	Greater New York Hospital Association and New York State Health Care Campaign
3/14/00	Health Care for the Uninsured
3/17/00	United Hospital Fund
3/21/00	Bureau of Child and Adolescent Health Public Forums
3/30/00	Medicaid Managed Care Operational Issues Workshop
4/6/00	Family Planning Advocates
4/7/00	Greater New York Hospital Association
4/14/00	New York State Advocate for Persons with Disabilities
4/24/00	Region II Family Planning Executive Directors' Retreat
5/2/00	Medical Technical Advisory Group
5/3/00	New York City Mayor's Office
5/23/00	Pharmacy Advisory Committee
5/23/00	New York State Health Care Campaign
5/24/00	Local District Department of Social Services (13 Counties and NYC)
5/25/00	Health Management Associates - Committee on Health Insurance for Indiana Families
6/13/00	New York State Coalition of Prepaid Health Services Plans
6/16/00	Native Americans
6/26/00	Health Plan Association

Representatives from 14 social services local districts have been providing technical assistance on community specific issues, concerns from urban, suburban and rural perspectives and identification of areas where existing programs and FHPlus should be aligned. The group will continue to provide valuable information on program administration and meet during the design and implementation of FHPlus.

B. Public Involvement

Following large-scale publicity when the HCRA 2000 legislation was signed, a high volume of public inquiries has been received via phone, letter and e-mail. These communications have been most helpful in understanding the plight of the uninsured, and provide specific case information about how access/or non-access to current coverage is affecting people's daily lives. Issues raised by public inquiries most often confirm the need for the higher income levels within FHPlus, and questions regarding coverage for those who consider themselves underinsured.

A web site page is under development regarding FHPlus to provide information on the program and its implementation, and to provide an opportunity for electronic feedback to and from the public. Following submission, a summary of this waiver request will also be available on the web site to encourage further feedback and recommendations from the public.

C. Next Steps

As program implementation nears, we recognize the importance of retaining the ongoing involvement of advocates for potential enrollees, the various types of plans which may be participating and the general public. As such, an intense set of meetings and conferences is being scheduled for the early summer to gain further feedback on key operational design issues.

In particular, additional meetings will be held with consumer advocacy groups, local district representatives and the Human Resources Administration of New York City regarding: development of eligibility review guidelines and the new application for FHPlus, recertification processes, plan accessibility, standards for plan approval, roles of the enrollment facilitators and benefit counselors. Special interest groups, such as Native Americans, will also be consulted.

Several meetings will also be held with groups of plan representatives to review the process of plan selection for FHPlus, the ratesetting approach being proposed, criteria for negotiation of rates, timing for starting the selection process, involvement of plans in the facilitated enrollment function and enrollment/recertification processes.

CHAPTER FOUR: RESEARCH AND EVALUATION

The FHPlus demonstration will provide timely information for New York State and the HCFA to:

- Understand the size, nature and utilization patterns of an expansion population which is currently uninsured;
- Provide information on the effectiveness of a fsimplified enrollment process;
- Measure the continuity of care and health outcomes for CHPlus "graduates;"
- Determine whether the availability of insurance leads to a greater likelihood of retaining employment;
- Assess the improvements in prudent health service use through managed care; and
- Determine the impact on existing employer insurance plans when publicly funded insurance coverage is introduced.

A. Evaluating Family Health Plus as a Prototype for Federal Initiatives

Several federal proposals have been advanced which would expand the availability of insurance coverage for the low-income, working poor who are currently unable to access public health benefits. FHPlus will provide a prototype for potential federal expansion of the SCHIP model of services to uninsured adults.

New York State's FHPlus demonstration will offer the federal government the immediate opportunity to evaluate this model of service delivery, identify operational issues, and measure responsiveness by the public. As such, it will provide a baseline of information, which will assist the federal government to design its "Family Care" type programs. The evaluation component will:

- Identify the specific types of enrollees who will enroll in an expanded State program for working adults.
- Measure the number of enrollees compared to projections; identify sub-populations of the target group who enroll over or under expectations.
- Test how the CHPlus service package meets the needs of this population, and identify any areas of difficulties.
- Identify barriers to participation including plan access, and propose solutions.
- Measure enrollee satisfaction and dissatisfaction with the program, how to enhance outreach and education, and improve navigation within the managed care environment.

Satisfaction surveys will include questions on enrollee health status before and after program implementation, to measure the impact of the availability of health care coverage through FHPlus.

B. Assessing the Effectiveness of Facilitated Enrollment

The use of facilitated enrollment at innovative and convenient sites for the working adult population should have positive outcomes, compared to the standard enrollment process. This component of the evaluation will assess the effectiveness of the revised enrollment process in achieving the following objectives:

- Improve access to Medicaid and CHPlus for eligible recipients through an enhanced presence in the community.
- Reduction in the stigma of welfare, and perceptions of governmental intrusion.
- More effective counseling for families to assure continuity of health care coverage and full access by the family members.
- Provide as seamless as possible transitions between programs (CHPlus/Medicaid/FHPlus/Healthy New York).
- Increase the rate of employment retention for populations transitioning off cash assistance or traditional Medicaid.

The DOH has established an online reporting system to monitor and evaluate facilitated enrollment which allows the DOH and the agencies to track an application's progress, note potential procedural problems, and record eligibility outcomes. This data will also allow the DOH to determine whether facilitators are reaching out to geographic areas of apparent under-enrollment in the past.

C. Measuring the Health Outcomes for CHPlus "Graduates"

By tracking young persons who transition from CHPlus to FHPlus when they reach the age of **19,** this demonstration will provide valuable information about the impact of family insurance on continuity of care for young adults. This will be accomplished by measuring ongoing health outcomes of a sample of children who become ineligible for CHPlus based on age, and transition to FHPlus.

D. Assessing Improvements in Prudent and Effective Health Service Use

By providing access to primary care and care management, FHPlus will encourage the appropriate use of health care services, avoiding overuse or misuse of emergency room and hospital care. Through the managed care model, preventive care and continual monitoring of ambulatory care sensitive conditions such as, asthma, diabetes, and high blood pressure, FHPlus is projected to improve long-term health outcomes, and to decrease inappropriate use of higher cost care.

Data reported through the Medicaid Encounter Data System will provide a source of comparative information for plans and will be used to monitor service utilization, evaluate access and continuity of service, monitor and develop quality and performance indicators, and analyze cost effectiveness. Utilization statistics will provide details on how specific services (outpatient and inpatient services, emergency room use and pharmacy services) are being accessed by enrollees in FHPlus.

E. Measuring the Impact on Maintaining Employer Insurance

This evaluation will measure whether the introduction of publicly-funded insurance for the low-income working poor will encourage employers to retreat from their existing levels of insurance coverage. Through measurements and monitoring of "crowd out," the following hypotheses will be tested:

- Employers will not significantly change the nature of coverage which they offer following implementation of FHPlus.
- Employees will not drop the coverage which they already have in order to join FHPlus.

CHAPTER V: ADMINISTRATION AND MANAGEMENT

FHPlus administration will be fully integrated into current Medicaid, Medicaid managed care and CHPlus operations to avoid the establishment of new and duplicative administrative structures. Because a key goal of FHPlus is to promote continuity of coverage for enrollees and their families, it is imperative that the organizational structure ensures full integration of functions with current public insurance programs. This approach is consistent with the comments of both plan representatives and advocacy groups which have stressed that this implementation of FHPlus should be aligned with current operations, communications and reporting requirements. Moreover, this approach will not only assist enrollees in obtaining better service, and limit the additional reporting burdens, but also improve the cost-effectiveness of administrative resources.

A. Current Administration

Since the submission of the original Partnership Plan waiver request, a series of departmental and organizational changes have occurred to improve and strengthen the accountability and coordination of Medicaid operations. The DOH is now the single State agency for Medicaid and the responsible agency for administration of Title XXI, as well as the agency responsible for the implementation and operation of the FHPlus program.

Within the DOH, key areas responsible for current Medicaid and CHPlus operations include:

- **The Office *of* Medicaid Management (OMM)** is responsible for overall Medicaid policy and operations, including interface with **HCFA,** management of the fee-for-service program and management of the key support services, including eligibility policy, systems support and claims processing. OMM maintains all Medicaid eligibility functions, liaison with the local districts, enrollment of fee-for-service providers, development of fee-for-service payment policies, prior approval

processes, drug utilization review, provider support services and education, provider audits and enforcement activities, and program data management, research and analyses.

- **The Office of Managed Care (OMC)** has primary responsibility for the operation of the current Section 1115 Partnership Plan Demonstration, including implementation of mandatory managed care, assuring quality of care through surveillance and quality reporting, plan review and approval, consumer satisfaction surveys, monitoring plans through the Quality Assurance Reporting Requirements, maintaining a hotline for enrollee inquiries, development of plan rates and rate adjustments, development and implementation of regulations, interface with HCFA regarding the intense monitoring and reporting processes included under the Partnership Plan, data analysis and research, and managed care data warehouse operation.

- **The Division of Planning, Policy and Resource Development (DPPRD)** is responsible for major policy issues and new initiatives in public health, health systems and health care finance, and operates the CHPlus program. CHPlus responsibilities include interfacing with HCFA on Title XXI administration, working with the State Insurance Department to ensure appropriate payment rates, establishing and maintaining quality of care for CHPlus, supervising accessibility, monitoring and reporting requirements, and supervising the enrollment process and associated training.

Working in concert, the three units within the DOH are provided additional support from:

- **Division of Legal Affairs,** which provides legal counsel, contract functions, interpretation of federal and State statute and regulations, and general legal guidance.
- **The Office of Intergovernmental Affairs,** which provides assistance with State and federal legislative affairs.
- **The Fiscal Management Group,** which provides administrative support regarding budgets, federal expenditure and funding guidelines, reporting requirements and administrative support for program operations.
- **Public Affairs Group,** which provides support with the design and production of outreach and education materials, public relations and statewide publicity.

Other agencies with responsibilities for administration of aspects of the Medicaid and CHPlus programs include the Division of the Budget, the State Insurance Department, the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services, the Office of Mental Retardation and Developmental Disabilities, and the local departments of social services, including the New York City Human Resources Administration. The Office of Temporary and Disability Assistance provides the fair hearing functions for the Medicaid program as well as for public assistance.

B. Proposed Organization

The administrative structure for FHPlus will involve a short-term approach during the initial implementation phase, followed by a permanent matrix organizational structure utilizing the existing areas of Medicaid and CHPlus management. As reflected previously in Figure 2, FHPlus operations will utilize the most effective aspects of both Medicaid and CHPlus, and these functions will be operated and supervised on an ongoing basis by those organizational units with existing expertise, reporting structures, data systems and experience.

During the intense design and implementation period, staff will be responsible to a centralized unit with sole responsibility for a timely and effective operation of the program. Existing staff has been reassigned to this unit, and will be augmented by new hires. Figure 8 provides the general organizational structure for this phase.

Reporting to the FHPlus leadership team led by the Medicaid Director, this interim unit will bring together the existing expertise necessary to complete planning and design work and assure not only that all functions are operational on schedule, but also assure consistency with current policies and operations. This approach has been utilized successfully to date through work teams composed of OMM, OMC and DPPRD personnel.

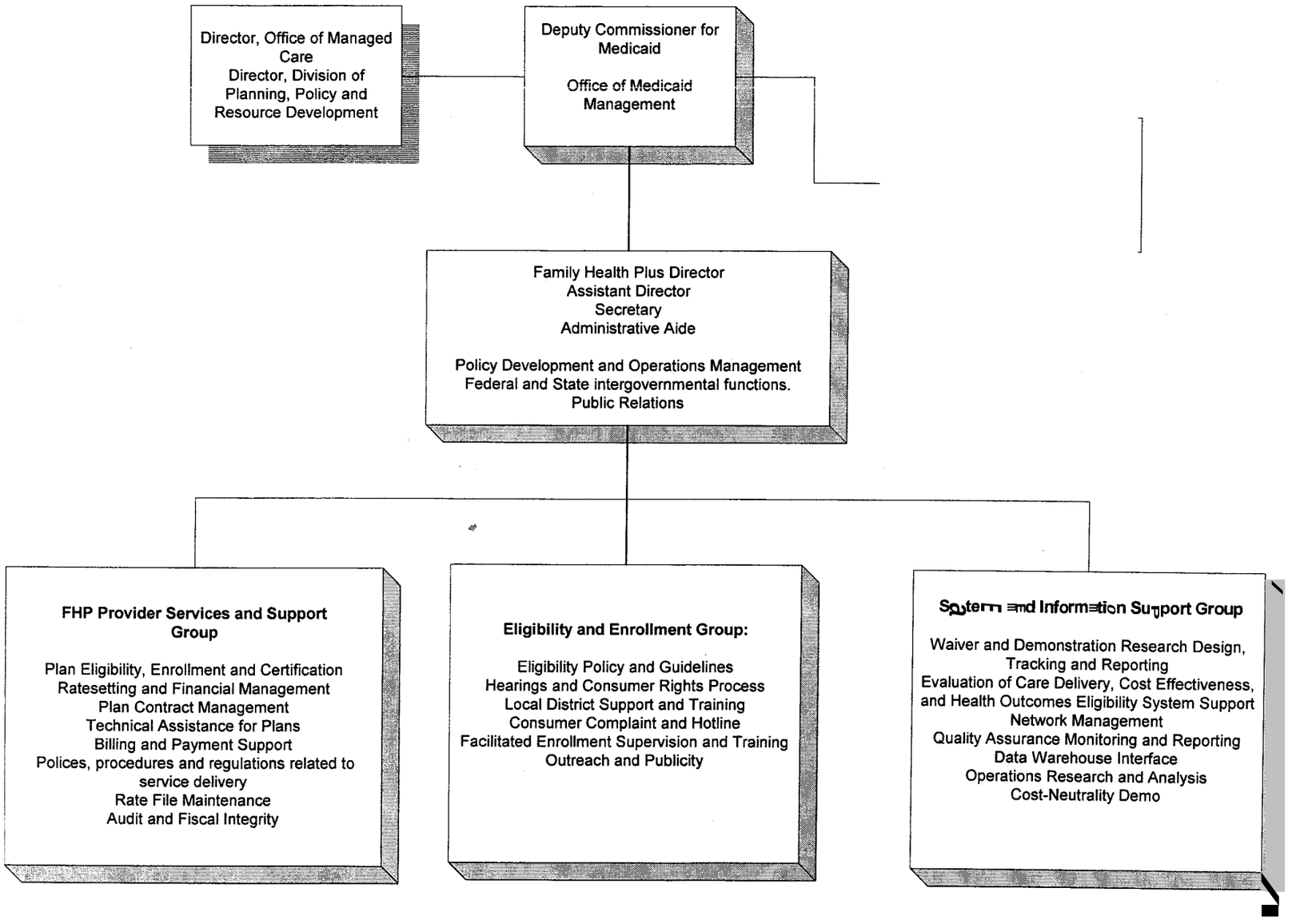
Once implementation is completed, a permanent matrix structure will be utilized to integrate all aspects of FHPlus operations into existing Medicaid and CHPlus operations. Staff will be reassigned to their operational units to undertake ongoing functions and address the increases in workload as a result of the FHPlus population. The Medicaid Director will continue to have overall responsibility for the FHPlus program.

C. Functional Responsibilities

Specific activities for ongoing operation of the FHPlus program will be undertaken as follows:

- Rate setting, plan certification and enrollment, quality assurance monitoring, access and reporting will be assumed by OMC, which completes these functions for the Partnership Plan.
- Facilitated enrollment expansion and ongoing supervision will be assumed by DPPRD, who has the extensive experience and ongoing responsibility for this function for CHPlus.
- Overall management and coordination, together with ongoing eligibility policies and procedures, eligibility and billing systems support, notifications to local districts, local district relations, and audit and enforcement functions will be managed by OMM.
- Research and evaluation of the waiver amendment will be jointly undertaken by OMC and OMM, with support from the DOH Fiscal Management Group.

Figure 8: Organizational Structure for FHPlus Design and Implementation



D. Ongoing Oversight and Involvement

A leadership team, consisting of the Medicaid Director, the Director of OMC and the Director of DPPRD will provide ongoing policy guidance, reporting to the Commissioner of Health. The leadership team will maintain an ongoing relationship with HCFA to assure that all necessary reporting and monitoring is maintained and that the terms and conditions associated with this waiver amendment are met.

To obtain ongoing feedback from interested parties, the set of existing key advisory groups for CHPlus, Medicaid and Medicaid managed care will be regularly advised regarding progress, key implementation issues and operational protocols for FHPlus. Ongoing meetings will also be held with plan representatives, advocacy coalitions and local district groups to include their involvement in the detailed implementation plans.

E. Workplan

Appendix 5 provides a summary workplan for the implementation of the FHPlus. Because the FHPlus legislation calls for a January 1, 2001 implementation date, developmental and design efforts are already underway.

CHAPTER SIX: CASELOAD AND COSTS

The following presents information on the approach to monitoring cost neutrality under this waiver amendment. Included are the assumptions and projections related to FHPlus enrollment, together with issues related to budget neutrality.

A. Enrollment Projections Under Family Health Plus

1. Assumptions Used for Eligible Population and Participation Rates

The number of people eligible to enroll in FHPlus was determined using New York State data from the two most recent years of the Current Population Survey (CPS). The data were broken down into adults age 19-64 with children, and adults without children (singles and childless couples). These groups were further classified as either "uninsured" (no health insurance for the entire previous calendar year) or "insured" (covered by non-Medicaid health insurance for some portion of the previous calendar year).

As described in Chapter Two, Section B, the FHPlus qualifying income standards increase over the first three years of the program, thereby increasing the total eligible pool each year. As of January 1, 2001, we estimate that 440,000 people will be eligible to enroll in FHPlus. As of October 1, 2001, 540,000 will be eligible, and as of October 1, 2002, 620,000 will be eligible. Figure 9 shows the estimated FHPlus eligibles broken out by New York City and Rest of State based on the income levels specified in State legislation.

Family Health Plus
Estimated Eligibles

As of:	120%FPL 1/1/01	133%FPL 10/1/01	150%FPL 10/1/02
NYC:			
Adults with children	105,000	159,000	198,000
Adults without children	134,000	134,000	134,000
Total NYC	239,000	293,000	332,000
Rest of State:			
Adults with children	67,000	112,000	154,000
Adults without children	133,000	133,000	133,000
Total Rest of State	200,000	245,000	287,000
Statewide:			
Adults with children	172,000	271,000	352,000
Adults without children	267,000	267,000	267,000
Totals for Statewide	439,000	538,000	619,000

Note: Adults without children remain at 100% FPL in all cases. Adults with children eligibility criteria increase from 120% FPL as of January 1, 2001 to 150% FPL as of October 1, 2002.

Maximum participation rates were then derived for both of the above populations that met the FHPlus income criteria. Based on experience in expanding the New York State Medicaid program, it is assumed that 50% of the total eligible uninsured population would participate in the program when FHPlus is fully implemented. Based on employment history and the type of health insurance (as measured by the CPS), we estimated that 30% of the total "insured" eligibles would not actually have insurance at the time they applied for FHPlus and, therefore, would participate in the program when it is fully implemented.

Full participation will be achieved gradually as the program phases in and as income levels for adults with children increase. The phase-in of the eligible uninsured population is expected to occur somewhat more rapidly for adults with children than for childless adults. This is based upon the expectation that eligible adults with children are more likely to be familiar with the CHPlus program and the facilitated enrollment process. In addition, adults with children are more readily available to marketing efforts by CHPlus plans who already have the children of these adults enrolled.

B. Integration into the Partnership Plan Cost Neutrality

1. Amendments to the Formula

The Terms and Conditions of the Partnership Plan Demonstration describe the method by which budget neutrality will be assured under the New York State Partnership Plan Demonstration. The budget neutrality provisions require amendment to incorporate the FHPlus program. Further, a number of issues have been identified since the original budget neutrality provisions were finalized which New York State seeks to address through this amendment. Additional issues are also likely to be identified during our discussions concerning this amendment in the upcoming weeks. A summary of the necessary amendments to the budget neutrality formula identified to date are as follows:

a. Add Medicaid Eligibility Groups (MEGs) and Per Member Per Month (PMPMs) for FHPlus Eligibles that Would Otherwise be Eligible Under a Medicaid Expansion

Attachment B of the original Partnership Plan to the Terms and Conditions states that, for purposes of calculating the overall expenditure limit for the Demonstration, separate budget estimates will be calculated for each year on a demonstration year basis. Each annual estimate is the sum of two components: an estimate of medical assistance expenditures for persons eligible for Medicaid under the current State plan participating in the demonstration, including those that could have been made Medicaid eligible under the Social Security Act, and an estimate of disproportionate share hospital (DSH) expenditures.

In addition, Attachment J, Terms and Conditions Associated with the Community Health Care Conversion Demonstration Project (CHCCDP), states that an allowance for CHPlus shall be included in the without waiver baseline to the extent that CHPlus is eligible for a federal match. New York State seeks the same consideration for FHPlus eligibles that would be eligible for federal match under a Medicaid expansion. The PMPMs for the FHPlus matchable population would be the same as those for the respective MA-Only AFDC MEGs, adjusted for benefit package differences.

b. Exclude the Cost of Family Health Plus Eligibles Without Children from the Budget Neutrality Formula

Consistent with New York State FHPlus legislation, the State seeks to exclude the costs of FHPlus adults without children from budget neutrality.

c. Subject SSI and MA-SSI Expenditures to the Budget Neutrality Cap from the Start Date of the Waiver

The current Terms and Conditions provide that, starting the day the demonstration is implemented, expenditures for all Partnership Plan eligibles in the AFDC and AFDC-related MEGs will be subject to the budget neutrality cap. However, expenditures for SSI and MA-SSI related Partnership Plan eligibles are not subject to the cap until mandatory enrollment of such individuals begins in any part of the State.

New York State seeks an amendment to the budget neutrality formula to subject SSI and MA-SSI expenditures to the budget neutrality cap effective on the October 1997 start date of the Demonstration. SSI and MA-SSI recipients have been included in the Demonstration since its inception and, therefore, there is no basis for excluding them from the calculation of the overall cap on expenditures. Also, this approach is consistent with the treatment of the AFDC population which are subject to the budget neutrality cap regardless of whether mandatory enrollment into managed care has started in the county or zip code.

d. Increase Without Waiver Expenditures to Reflect the Impact of the Balanced Budget Act on Payments to Federally Qualified Health Centers

Section 11, Legislation, of the Terms and Conditions states that New York State will comply with changes in federal law affecting the Medicaid program that occur after July 15, 1997. Further, the Terms and Conditions provide that to the extent that a change in federal law, which does not exempt State section 1115 demonstrations, would affect State Medicaid spending in the absence of a waiver, HCFA shall incorporate such changes into a modified budget limit.

Notwithstanding the State's 1115 waiver, HCFA has determined that the provisions of the Balanced Budget Act that require supplemental payments to

Federally Qualified Health Centers for visits by Medicaid managed care enrollees apply to the State. The effective date of the Balanced Budget Act is October 1, 1997. Consistent with the Terms and Conditions, the State seeks the inclusion of the estimated cost of these supplemental payments absent a waiver in the budget neutrality cap.

e. Increase Without Waiver Expenditures to Reflect Federal Directives Related to School Supportive Health Services

New York State filed a State Plan Amendment effective October 1996 to replace EPSDT Administration with a Targeted Case Management program under School Supportive Health. This change was made at HCFA's recommendation. The PMPMs agreed upon between HCFA and the State were calculated using State fiscal year 1995-96 claims data. Therefore, the expenses associated with this component of School Supportive Health are not reflected in the PMPMs used for calculating the budget cap. The State seeks the inclusion of the cost of these services in the budget neutrality cap.

f. Modify Calculation to Conform to the Terms of the Waiver

HCFA's approval of the existing waiver extends through March 31, 2003. New York State seeks to discuss with HCFA any modifications to the budget neutrality formula needed to reflect the term of the waiver.

2. Cost and Trend Projections for Family Health Plus

Consistent with the amendment in Chapter Six, B.1**.a,** the without waiver PMPM costs for FHPlus adults with children are the same as the respective MA-Only AFDC adult MEG. For each demonstration year, the PMPMs are trended forward using the approved MA ADC trend factors in the existing waiver?

The with waiver FHPlus cost projections were developed using estimated premiums that will be paid to managed care plans for this population. The estimated premiums will be developed using the same budget actuarial methodology used to develop the existing waiver population premiums. The existing methodology includes the provision that managed care premiums will on average be no greater than what would be paid in a fee for service environment. Thus, costs for the FHPlus population were developed using 95% of the most current ADC adult Upper Payment Limit (UPL) available. Separate UPLs were determined for New York City and the rest of state. The UPLs were adjusted to reflect the inclusion of pharmacy benefits, and trended forward by the approved ADC adult trend factors used in the existing waiver for each demonstration year.

3. Achieving Cost Neutrality

Based on the amendments to the formula, inclusion of the FHPlus population with the waiver will not adversely impact budget neutrality over the term of the waiver.

CHAPTER SEVEN: WAIVERS AND AMENDMENTS REQUESTED

A. Waivers Requested

In order to implement the proposed FHPlus demonstration project, New York State must receive waivers of certain statutory and regulatory requirements, including (a) eligibility standards, (b) amount, duration and scope of services, (c) state-wideness (in terms of uniformity of service delivery), (d) freedom of choice, and (e) any other requirements that would prevent full implementation of the program. Under the Partnership Plan, a number of waivers have already been approved. In many cases, these waivers are applicable to FHPlus, but additional waivers, or waivers for different reasons, are also required. The key requirements that New York State requests be waived for this amendment include the following:

1. Eligibility Standards

Section 1902(a)(10)(A) of the Social Security Act ("SSA") and 42 C.F.R. Part 435 requires states to make medical assistance available to certain categories of individuals who meet the qualifications of that subparagraph of the SSA and affords states the opportunity to provide coverage to additional categories of individuals. New York State's FHPlus program will provide health care services to uninsured individuals in the State who have gross incomes up to 150% of the FPL. Also, New York State's FHPlus program does not employ income disregards or a resource test for eligibility determinations but does make lack of equivalent health care coverage a condition of eligibility. Waivers of the above federal requirements will, therefore, be needed. In addition, the State is requesting Federal Financial Participation for FHPlus eligible who are single individuals and childless couples, as defined in this proposal.

2. Income Levels and Resource Disregards

Section 1902(a)(17) of the SSA establishes procedures for taking into account the income and resources of individuals who are not receiving public assistance under the AFDC rules in effect on July 16, 1996 or Supplemental Security Income. New York State requests a waiver of this section to the extent necessary to waive the resource limitations for individuals eligible for FHPlus as described in detail in Title II-D of the New York State Social Services Law and summarized in Section 1 above.

3. Amount, Duration, and Scope of Services

Section 1902 (a)(10)(B) requires that the medical assistance made available to individuals who fall within the categories described in **SSA** § 1902(a)(10)(A) be the same in amount, duration, and scope for all recipients of those services. **As** specified in greater detail in the services description component of this application, enrollees in FHPlus will receive a comprehensive package of health care services but not the complete array of health care services provided to traditional medical assistance recipients. In addition, dental care is an option that approved plans may, but are not required, to provide. Consequently, New York State must obtain a waiver of this requirement in order to implement the program.

4. Statewideness

Section 1902(a)(1) and 42 C.F.R. §440.230-250 require that a state's plan for medical assistance must be in effect for all Medicaid enrollees in all political subdivisions of the State. In New York State, types and degree of selection of managed care plans available under the demonstration program will vary by geographical location although the benefits offered will essentially be the same. Certain counties may have no managed care plans, requiring health care services to be provided through approved commercial insurers. For these reasons, New York State requests a waiver of this requirement.

5. Retroactive Eligibility

Section 1902(a)(34) and 42 C.F.R. § 435.914 require states to provide medical assistance retroactively for up to three months prior to the date that the application for medical assistance was made. The New York State FHPlus program does not provide for retroactive eligibility for applicants in this program. New York State requests a waiver of this requirement for the FHPlus population.

6. Freedom of Choice

Section 1902(a)(23) and 42 C.F.R. § 431.51 (b) require a State Plan to provide that any individual eligible for medical assistance may obtain health care services from any provider qualified to provide those services. The FHPlus program will allow participants to choose among available participating plans, and network providers in the plan selected. Certain counties may have only one plan or insurer offering FHPlus. In these areas, enrollees will be limited to a single plan for access to FHPlus. In addition, because there is no fee-for-service component of the program, enrollees will be able to receive family planning services only within the plan they have selected. To the extent that the requirement that services be obtained from network providers is viewed as a restriction on participants' freedom of choice, a waiver is necessary.

7. Guaranteed Eligibility

Subject to the availability of Federal Financial Participation("FFP"), the FHPlus program will provide six-month guaranteed eligibility to enrollees from the date of enrollment in a Family Health Plus plan. SSA §1902 (e)(2) (A) provides for a six-month guaranteed eligibility period only for individuals enrolled in certain types of managed care organizations or other approved entities specified in sections 1903m(1)), 1905(t), and 1876 of the **SSA.** New York State requests a waiver of the restriction on guaranteed eligibility in order to maximize plan participation and stability.

8. Utilization and Quality of Care Review

New York State requests a waiver from sections 1903(g), 1902(a)(26), (30), and (31) of the SSA to the extent that those provisions contain minor technical differences between federal requirements and New York State's stringent utilization review and quality of care requirements.

In addition to the above specific waiver requests, New York State requests that HCFA grant any other waiver under section 1115 of the SSA that HCFA determines is necessary for implementation of this demonstration project.

B. Amendments to Partnership Plan Terms and Conditions

This amendment proposes the expansion of Medicaid coverage to a new population of eligibles, the provision of a selected set of benefits, modifications to eligibility standards and development of a new service delivery system. Because of the nature of this amendment, compared to the original Partnership Plan, a number of the programatic terms and conditions for the original demonstration are not relevant for the new population and service delivery system under this amendment.

A review of the current Partnership Plan Terms and Conditions was completed to evaluate their applicability. In general, there are a large number of requirements which are applicable, and administration by both HCFA and DOH would be eased through consistent application of these requirements (i.e., reporting requirements, etc). However, a number of other requirements are simply not relevant to the FHPlus amendment request, such as requirements related to auto-assignment of participants, SNPs, local district contracting requirements, etc. In other cases, a portion of the term or condition is inapplicable, while the remainder would be appropriate.

New York State is requesting that adjustments and modifications to the Partnership Plan Terms and Conditions be made to clarify which are inapplicable in whole or part for the FHPlus component of the waiver. Although the terms and conditions for this amendment request would not be finalized until after the waiver request has been approved, New York State wishes to receive assurances that the Partnership Plan

Terms and Conditions will be modified for FHPlus. An initial evaluation will be forwarded separately.

As described in Chapter Six, amendments to certain terms and conditions related to budget neutrality will also be required.

C. Additional Conditions Requested

This waiver amendment request is to implement a program which is similar in scope and nature to federal proposals to expand coverage to adults under SCHIP. Discussions about similar federal proposals are ongoing. New York State is requesting assurance that, should a program similar to FHPlus be adopted in the future, and include the enhanced federal matching rate available under Title XXI, that New York State be eligible for retroactive reimbursement for equivalent State expenditures under the waiver request.